South Dakota

UNIFORM APPLICATION
FY 2009 - STATE PLAN

COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 08/20/2007 - Expires 08/31/2009

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Center for Mental Health Services
Division of State and Community Systems Development

Introduction:

The CMHS Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0168.

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South Dakota

FACE SHEET

FISCAL YEAR/S COVERED BY THE PLAN

__FY2009 __FY 2009-2010 __FY 2009-2011

STATE NAME: South Dakota

DUNS #: 809587678

I. AGENCY TO RECEIVE GRANT

AGENCY: Department of Human Services

ORGANIZATIONAL UNIT: Division of Mental Health

STREET ADDRESS: Hillsview Properties Plaza, East Highway 34, c/o 500 East Capitol

CITY: Pierre STATE: SD ZIP: 57501-5070

TELEPHONE: (605) 773-5990 FAX: (605) 773-5483

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: Jerry C. Hofer TITLE: Secretary of Human Services

AGENCY: Department of Human Services

ORGANIZATIONAL UNIT: Secretariat

STREET ADDRESS: Hillsview Prperties Plaza, East Highway 34, c/o 500 East Capitol

CITY: Pierre STATE: SD ZIP CODE: 57501-5070

TELEPHONE: (605) 773-5990 FAX: (605) 773-5483

III. STATE FISCAL YEAR

FROM: 07/01/2007 TO: 06/30/2008

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: Amy Iversen-Pollreisz TITLE: Director of the Division of Mental Health

AGENCY: Department of Human Services

ORGANIZATIONAL UNIT: Division of Mental Health

STREET ADDRESS: Hillsview Properties Plaza, East Highway 34, 500 East Capitol

CITY: Pierre STATE: SD ZIP: 57501-5070

TELEPHONE: (605) 773-5990 FAX: (605) 773-7076 EMAIL: Amy.Iversen-Pollreisz@state.sd.us

South Dakota

Executive Summary

Please respond by writing an Executive Summary of your current year's application.

Attachment A

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2009

I hereby certify that South Dakota agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:

Subject to Section 1916, the State[1] will expend the grant only for the purpose of:

i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:

ii. Evaluating programs and services carried out under the plan; and

iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

(c)(1)& (2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms adults with a serious mental illness and children with a severe emotional disturbance and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2008, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

21. The term State shall hereafter be understood to include Territories.

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a service area)
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.
(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]

(c) The State will:
(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will:
(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

_____ _____

Governor Date
Jerry C. Hofer, Secretary of Human Services

OMB Approval No. 0920-0428

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub- grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--
  (1) The dangers of drug abuse in the workplace;
  (2) The grantee's policy of maintaining a drug-free workplace;
  (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
  (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  (1) Abide by the terms of the statement; and
  (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical an mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Secretary of Human Services
APPLICANT ORGANIZATION S.D. Department of Human Services	DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. **Type of Federal Action:**	2. **Status of Federal Action**	3. **Report Type:**
☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	☐ a. bid/offer/application b. initial award c. post-award	☐ a. initial filing b. material change **For Material Change Only:** Year _____ Quarter _____ date of last report _____

4. **Name and Address of Reporting Entity:**	5. **If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:**
Prime Subawardee Tier _____ , *if known:* **Congressional District**, *if known:*	**Congressional District,** *if known:*
6. Federal Department/Agency:	7. **Federal Program Name/Description:** **CFDA Number**, *if applicable:* _____
8. **Federal Action Number,** *if known:*	9. **Award Amount,** *if known:* **$**
10. a. Name and Address of Lobbying Entity *(if individual, last name, first name, MI):*	**b. Individuals Performing Services** *(including address if different from No. 10a.)* *(last name, first name, MI):*
11. **Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.**	**Signature:** _____ **Print Name:** _____ **Title:** _____ **Telephone No.:** _____ **Date:** _____
Federal Use Only:	Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks "subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., ''RFP-DE-90-001.''

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in con- struction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, re- gulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Secretary of Human Services
APPLICANT ORGANIZATION S.D. Department of Human Services	DATE SUBMITTED

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South Dakota

Public Comments on State Plan

Section 1941 of the Block Grant legislation stipulates that as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State Plan. States will make the mental health plan public in such a manner to facilitate comment from any person (including Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

States should describe their efforts and procedures to obtain public comment on the plan on the plan in this section.

Public Comment

The Mental Health Advisory Council and the Division of Mental Health (DMH) begin preparing the Block Grant application by identifying priorities for improving the community mental health system. After identification of priority areas, the Advisory Council and the Division of Mental Health develop goals and tasks related to each priority area. Throughout the year, the DMH and members of the Advisory Council are also participants on many task forces, workgroups, planning groups, and committees with representatives of other stakeholder groups. Participation in these groups provides opportunities for the DMH to obtain additional input from a larger pool of individuals and agencies on important issues to consider for improvement of the community-based mental health system.

Once a draft of the State Plan is created, copies are distributed to Advisory Council members for review. Advisory Council members representing stakeholder groups, such as National Alliance for Mental Illness-South Dakota (NAMI-SD) and South Dakota Advocacy Services share the draft plan with their group membership to solicit comments. Consumers and family members share the draft State Plan with individuals within their local communities as well as other consumer/family advocates. In addition, comments are solicited from the Council of Mental Health Centers and each community mental health center.

Public notices are placed in several South Dakota newspapers notifying the public of the draft and requesting feedback and/or participation in the Council meeting held the month prior to the submission due date. Information provided in the public notice includes:

- A description of the Mental Health Block Grant;
- Deadline date to give input into the development of the Plan;
- Information about where to find the State Plan on the DMH's website;
- Contact address and phone number for submission of written comments

Additionally, the DMH makes available to the public the current State Plan and the previous year's Implementation Report on the DMH website. The website for the current plan and report is http://dhs.sd.gov/dmh/forms. The DMH also mails out copies of the State Plan to individuals who do not have access to a computer.

II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

States are required to provide systems of integrated services for children with serious emotional disturbances(SED). Each year the State shall expend not less than the calculated amount for FY 1994.

Data Reported by:

State FY X **Federal FY** _____

State Expenditures for Mental Health Services

Calculated FY 1994	Actual FY 2007	Estimate/Actual FY 2008
$689452	$721815	$

Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

The FY 2006 expenditure amount of $721,815 reflects the FY 2006 estimated amount reported in calendar year 2005. The FY 2005 expenditure amount of $689,453 below reflect actual FY 2006 expenditures. State Expenditures for Children's Services By Budget Line Item Calculated Actual Actual/Est. Estimated Estimated 1994 2005 2006 2007 2008 $689,452 $710,932 $689,453 $721,815 $721,815 Minimum Required($689,452)($689,452) ($689,452) ($689,452) Over(Under)Reqd $ 21,480 $ 1 $ 32,363 $ 32,363

III. MAINTENANCE OF EFFORT(MOE) REPORT

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion.

States are required to submit State expenditures in the following format:

MOE information reported by:

State FY __X__ **Federal FY _____**

State Expenditures for Mental Health Services

Actual FY 2006	Actual FY 2007	Actual/Estimate FY 2008
$7,540,794	$8,101,609	$

MOE Shortfalls

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall. These conditions are described below.

(1). Waiver for Extraordinary Economic Conditions

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

(2). Material Compliance

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.

The FY 2005 expenditure data amount of $7,417,509 reflects the FY 2005 estimated amount which was reported in calendar year 2004. The FY 2005 expenditure amount of $7,613,817.45 below reflects actual expenditures for FY 2005. State expenditures for community mental health services were provided for the following programs: Emergency Services, Indigent Medication, Community & Residential, Services for Children, SPMI Adult Care Program, SPMI Dual Diagnosis, and Intensive Family Services. The expenditure data supplied represents state expenditures covering the state fiscal year period. Therefore, the following expenditure data is for state fiscal years 2005, 2006, 2007, and budgeted / estimated state fiscal year 2008. The following is a summary of state expenditures maintained for Community Mental Health Services during state fiscal year 2007 and the calculation of the average level of expenditures maintained for the two year period preceding SFY 2007. Actual SFY 2007 $8,101,609.00 Actual SFY 2006 $ 7,540,793.73 Actual SFY 2005 $ 7,613,817.45 $15,154,611.18 / 2 = $7,577,305.59 Over (Under) Required Maintained $ 524,303.41 The amount of state expenditures maintained for SFY 2007 exceeded the two year period average by $524,303.41. This represents an amount that is “over” our required maintenance of effort and reflects compliance with the maintenance of effort requirement in Section 1915. The following is a summary of state expenditures estimated to be maintained for Community Mental Health Services during SFY 2008 and the calculation of the average level of expenditures maintained for the two year period preceding SFY 2008. Estimated/Budgeted SFY 2008 $8,689,856.00 Actual SFY 2007 $ 8,101,609.00 Actual SFY 2006 $ 7,540,793.73 $15,642,402.73/ 2 = $7,821,201.37 Over (Under) Required Maintained $ 868,654.63

TABLE 1. List of Planning Council Members

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Arends, Phyllis	Others(not state employees or providers)	NAMI	218 N. Seventh Ave. Canistota,SD 57012 PH:605-296-3219 FAX:	wparends.@unitelsd.com
Bird, Richard	Providers		388 Dakota Ave Sisseton,SD 57262 PH:605-698-3517 FAX:	richard.bird@swst.us
Claymore-Lahammer, Vickie	Providers	Indian Health Services	115 4th Ave SE Room 309-Federal Building Aberdeen,SD 57401 PH:605-226-7341 FAX:	vickie.claymore-lahammer@ihs.gov
Dosch, Daniele	Family Members of Children with SED		1019 Fulton Street Rapid City,SD 57701 PH:605.718.0747 FAX:	ddosch@rushmore.com
Grimme, Bernie	State Employees	Vocational Rehabilatation	Department of Human Services Hillsview Plaza, E. Hwy 34,c/o 500 E. Capitol Pierre,SD 57501 PH:605-773-4644 FAX:	bernie.grimme@state.sd.us
Hanson, DJ	State Employees	Criminal Justice	500 E. Capitol Pierre,SD 57501 PH:605-773-3474 FAX:	dj.hanson@state.sd.us

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Herrmann, Doug	State Employees	Criminal Justice	1600 Sedivy Lane Rapid City,SD 57703 PH:605-394-1617 FAX:	doug.herrmann@state.sd.us
Iversen-Pollreisz, Amy	State Employees	Mental Health	Department of Human Services Hillsview Plaza, E. Hwy 34, c/0 500 E. Capitol Pierre,SD 57501 PH:605-773-5991 FAX:	amy.iversen-pollreisz@state.sd.us
Kean, Robert	Others(not state employees or providers)	South Dakota Advocacy Services	221 South Central Pierre,SD 57501 PH:605-224-8294 FAX:	keanr@sdadvocacy.com
Knoke, Lois	Consumers/Survivors/Ex-patients(C/S/X)		1601 Ohio Ave SW #209 Huron,SD 57350 PH:605-352-2709 FAX:	ljknoke@hur.midco.net
Kornder, Susan	Providers	Northeastern Mental Health Center	628 Circle Drive PO Box 550 Aberdeen,SD 57401 PH:605-225-1010 FAX:	skornder@nemhc.org
Larsen, Ann	State Employees	Education	Special Education Programs Kneip Building, 700 Governors Drive Pierre,SD 57501 PH:605-773-3678 FAX:	ann.larsen@state.sd.us

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Lautenschlager, Amanda	Family Members of Children with SED		1523 S. Lincoln St. Aberdeen,SD 57401 PH:605-622-7997 FAX:	alaut@abe.midco.net
Lefdal, Barb	Family Members of adults with SMI		5201 W. Royal St. Sioux Falls,SD 57106 PH:605-361-6091 FAX:	barblefdal@yahoo.com
Majeres, Duane	Providers	Community Counseling Services	357 Kansas Ave SE Huron,SD 57350 PH:605-352-8596 FAX:	dumajeres@ccs-sd.org
Nelson, Cory	State Employees	Mental Health	PO Box 7600 Yankton,SD 57078 PH:605-668-3102 FAX:	cory.nelson@state.sd.us
Palm, Rhonda	Consumers/Survivors/Ex-patients(C/S/X)	NAMI	10367 457th Ave New Effington,SD 57255 PH:605-652-4611 FAX:	
Pedersen, John	Others(not state employees or providers)	Public Educator	PO Box 1075 Pierre,SD 57501 PH:605.773.2525 FAX:	john.pedersen@sasd.org

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Peterson-Olson, Roseann	Consumers/Survivors/Ex-patients(C/S/X)		21163 456th Ave Arlington,SD 57212 PH:605-983-5726 FAX:	rose.olson@hotmail.com
Polak, Lorraine	State Employees	Housing	221 South Central PO Box 1237 Pierre,SD 57501 PH:605-773-4567 FAX:	vona@sdhda.org
Shroll, Bill	Consumers/Survivors/Ex-patients(C/S/X)		PO Box 1432 Watertown,SD 57201 PH:605-886-5273 FAX:	bldschroll@yahoo.com
Sonnenschein, Sharon	State Employees	Medicaid	Kneip Building 700 Governors Drive Pierre,SD 57501 PH:605-773-3165 FAX:	sharon.sonnenschein@state.sd.us
Washenberger, Ellen	Family Members of adults with SMI		421 15th Ave NE Aberdeen,SD 57401 PH:605-226-3086 FAX:	ewashen@lsssd.org
White Plume, Ramona	Family Members of Children with SED		PO Box 325 Porcupine,SD 57772 PH:605-867-2883 FAX:	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
York, Jane	Family Members of adults with SMI		152 Lewis and Clark Trail Yankton,SD 57078 PH:605-665-3022 FAX:	jyork@bop.gov

TABLE 2. Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	25	
Consumers/Survivors/Ex-patients(C/S/X)	4	
Family Members of Children with SED	3	
Family Members of adults with SMI	3	
Vacancies(C/S/X and Family Members)	0	
Others(not state employees or providers)	3	
TOTAL C/S/X, Family Members and Others	13	52.00%
State Employees	8	
Providers	4	
Vacancies	0	
TOTAL State Employees and Providers	12	48.00%

Note: 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council, 2) State Employee and Provider members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services. 4) Totals and Percentages do not include vacancies.

South Dakota

Planning Council Charge, Role and Activities

State Mental Health Planning Councils are required to perform certain duties. If available, a charter or a narrative summarizing the duties of the Planning Council should be included. This section should also specify the policies and procedures for the selection of council members, their terms, the conduct of meetings, and a report of the Planning Council's efforts and related duties as mandated by law:

reviewing plans and submitting to the State any recommendations for modification
serving as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems,
monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health services within the State.
the role of the Planning Council in improving mental health services within the State.
<STRONG>In addition to the duties mandated by law, States should include a brief description of the role of the Planning Council in the State's transformation activities that are described in Part C, Section II and Section III. </STRONG>

Planning Council Charge, Role, and Activities

The Governor of South Dakota appoints the Mental Health Planning and Coordination Advisory Council members. As written in South Dakota Codified Law (SDCL) 27A-3-1.1-1.5, the Advisory Council, in collaboration with the Department of Human Services and the Division of Mental Health performs functions in the following areas:

- Development and modification of any necessary state or federal mental health plans;
- Influencing and achieving greater coordination of planning and service delivery efforts among various federal, state, local, or private agencies involved in the mental health service delivery network;
- Policy related matters and matters related to the allocation of federal and state funds to the mental health centers in the state and the South Dakota Human Services Center (single state psychiatric inpatient facility);
- Matters concerning regulation, staff requirements, administration, audit and record keeping, and services to be provided by mental health centers and the South Dakota Human Services Center;
- The Council meets quarterly and prepares an annual written report for the Governor by December 1 of each year;
- Continuous work on identification of needed program and service expansion and achievement of the highest possible quality service;

The Advisory Council has a diverse membership that are excellent advocates for all individuals needing mental health services within the state, including adults with severe and persistent mental illness (SPMI) and children with serious emotional disorders (SED). Membership on the Council includes:

- Consumers
- Family members of individuals with SPMI/SED
- Consumer/Family Advocacy organizations
- South Dakota Advocacy Services
- Providers of community mental health services
- Public Educator/Administrator
- Division of Mental Health Director
- Administrator of the Human Services Center-state's only inpatient psychiatric facility
- Department of Social Services-which includes the State Medicaid Office
- Division of Vocational Rehabilitation
- South Dakota Housing Authority
- Department of Education- Director of Special Education
- Indian Health Services
- Department of Corrections
- Unified Judicial Systems

The Mental Health Planning and Advisory Council membership includes three family members of children with serious emotional disturbances (SED). This ratio of parents of

children with SED to other members of the Council provides important representation of children and family mental health issues in the deliberations of the Council. The State Mental health Planning Council also has representation from three family members of adults with severe and persistent mental illness, including a family member of an older (age 62 or older) adult. As stipulated by law, the majority of individuals (52%) are individuals who are not State employees or providers of mental health services. In addition, a joint representative position was created that would sit on both the Mental Health and the Alcohol and Drug Advisory Councils. This position shares information across the councils, thereby increasing the collaborative efforts toward development of integrated treatment for individuals with co-occurring disorders. See Attachment 1, Mental Health Planning and Coordination Advisory Council By-laws, for council specific membership, purpose, meeting, and coordination requirements.

The Advisory Council meets quarterly and has two standing committees-the Adult Subcommittee and the Children's Subcommittee. These subcommittees allow for discussions that are more detailed for input from not only Advisory Council members, but also the public. The Subcommittees meet on an as needed basis on the day before the full council meetings. In addition, the Advisory Council created a subcommittee on Quality of Care in June 2008. This subcommittee is focusing on specific issues related to quality of mental health care in community mental health centers. This includes researching workforce development, cultural competence, and staff to consumer ratios. The subcommittee will compile the results and make recommendations back to the Council on development of plans to address identified issues.

As discussed above, one of the main roles of the Advisory Council is to monitor, review, and evaluate the allocation and adequacy of mental health services within the state. The Division of Mental Health and the Advisory Council work closely together to establish and maintain an organized system of care that is consumer/family driven, strength-based, and recovery oriented. Through strategic planning, the Division of Mental Health and the Mental Health Planning and Coordination Advisory Council identify needs and priorities for the community mental health system. The President's New Freedom Commission on Mental Health's final report drives the process of planning for ways to improve the system of care for adults and children with mental illnesses. In addition, the Advisory Council plays a key role in the advancement of transformational activities across the state, including development of systems of care (SoC) for children/families, individualized and recovery oriented mental health services, and development of services for individuals with co-occurring mental health/substance use disorders.

South Dakota

Adult - Overview of State's Mental Health System

Adult - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

Overview of the State's Mental Health System

The Department of Human Services

The Department of Human Services includes the following divisions: Alcohol and Drug Abuse; Developmental Disabilities; Rehabilitation Services, Service to the Blind and Visually Impaired; Mental Health; as well as the South Dakota Developmental Center and the Human Services Center (the only state-operated, inpatient facilities for developmental disabilities and mental health respectively).

The Division of Mental Health

As the State Mental Health Authority, the Division of Mental Health (DMH), under the auspices of the South Dakota Department of Human Services (DHS) is responsible for the administration of a comprehensive, community-based mental health delivery system. The DMH also provides mental health services and oversight for a contract psychiatrist in the State Correctional facilities. The Division of Mental Health staff consists of:

- a full-time director;
- a program manager for community mental health services who oversees two program specialists;
- a program manager for correctional mental health services who oversees a contract psychiatrist, fourteen mental health professionals and one secretary in the adult correctional facilities, and two mental health professionals for the juvenile correctional facilities;
- a community and corrections program specialist who works with the correctional mental health manager and oversees two additional program specialists;
- a secretary

See Attachment 2 for the Division of Mental Health Organizational Chart.

The principle responsibilities of the DMH are to establish policy; to develop and administer the implementation of the Community Mental Health Services Block Grant; to determine and establish reasonable standards and requirements for the locally operated community mental health centers; and, to enter into purchase of services agreements for the purpose of assisting in the operation and programs of the local mental health centers. The DMH provides a range of services through purchase of service agreements with the eleven private, non-profit, community mental health centers (CMHCs). Each mental health center is governed by a local board of directors and each center has a specific geographic service area for which it is responsible. See Section I- Description of Regional Resources for a more complete description of the community mental health center catchment areas. These catchment areas provide mental health services to all 66 counties in the state. See Attachment 3 for the map of community mental health service areas. The Division targets funding to adults with severe and persistent mental illness (SPMI) and children with serious emotional disturbances (SED) and their families. The Division of Mental Health also has the responsibility for the delivery of mental health services within the State's adult and juvenile correctional facilities.

Consumers & Families

The Mental Health Planning and Advisory Council maintain an ongoing and proactive relationship with the Division of Mental Health (as described in Planning Council Charge, Role, and Activities). Consumer and family advocacy groups are essential to South Dakota's mental health system. In October 2007, the Division of Mental Health (DMH) again collaborated with NAMI- South Dakota (National Alliance on Mental Illness) for the annual statewide NAMI Conference. NAMI-SD has nine affiliates across the State and boasts a state-wide Consumer Council. The Division of Mental Health collaborates with NAMI- SD in providing information and articles for their bi-monthly newsletter as well as providing conference call services for the Consumer Council to have monthly calls. In an effort to build awareness and provide information on mental illness, the DMH contracts with a consumer to present the "In Our Own Voice" Program to provide training and information to law enforcement officers on mental illness during Law Enforcement Academy Training. The Division of Mental Health also works with South Dakota Advocacy Services, whose mission is "To protect and advocate the rights of South Dakotans with disabilities through legal, administrative, and other remedies."

During early 2008, consumers across the state came together to begin development of a statewide consumer advocacy organization. In March 2008, the National Empowerment Center provided a Finding Your Own Voice technical assistance workshop to consumers. The Division of Mental Health was able to provide stipends to 45 consumers from across the state to attend the workshop. These consumers have developed a strong beginning for consumer advocacy within the State of South Dakota. Consumers came away from the training with a united voice, a name for the organization (South Dakota United for Hope and Recovery (SDUnited)), and a vision statement for SDUnited. They also formed a planning committee, whose members are now working on the steps needed to create a formal statewide consumer advocacy organization.

Barbara Huff has provided technical assistance to South Dakota families in the promotion of the establishment of a family run advocacy organization that focuses solely on meeting the needs of children and youth with emotional, behavioral, and mental health challenges and their families. Currently, the parent of a child with a serious emotional disorder has been identified to work in parallel with Barbra Huff to pull families together into an organized system of advocates. While the formation of this important organization is in the early stages, they are already helping to build advocacy efforts for families involved in the System of Care Pilot Project in Rapid City. The establishment of family involvement and advocacy, as well as leadership will help drive transformation in the State mental health system.

The Human Services Center

The administration of the Human Services Center is under the Secretariat, rather than the Division of Mental Health (the state mental health authority). The Human Services Center, located in the southeastern tip of South Dakota, is the only state-operated, licensed hospital, providing inpatient psychiatric treatment services, and chemical dependency treatment services. The Human Services Center provides the following services and programs:

- Inpatient psychiatric treatment services. Acute Psychiatric Services has a total bed capacity of 60. This area is Medicare approved by the Center for Medicare and Medicaid Services. Acute Psychiatric Services provides for initial assessment of adult patients and development and initiation of treatment and discharge plans. Acute Psychiatric Services, like all HSC treatment programs, promotes and facilitates independent functioning in daily activities and provides care, treatment and rehabilitation services that will enable the patient to return to and function in the community at the earliest possible time.

- The Psychiatric Rehabilitation Program provides services for adult patients who are coping with persistent mental illness and who need to remain at the hospital for longer periods of time. The goal of the program is to assist the patients in developing skills that will help them to live in the least restrictive setting possible. The psychiatric rehabilitation program is made up of 61 beds.

- The Adolescent Acute Psychiatric Program provides adolescents, ages 12 through 17, with inpatient psychiatric evaluation and treatment. The goal of the program is to develop and initiate individualized treatment and discharge plans, provide effective treatment, and to support the patient in transition to home or another appropriate placement setting. This program contains 15 beds. Adolescents from this program attend an accredited Alternative School operated by HSC. An intermediate adolescent psychiatric unit is also available. This unit provides additional support and a slightly longer stay than the acute unit. This unit consists of 20 beds and serves adolescents ages 12 through 17.

- Long-Term Adolescent Treatment Program provides long-term psychiatric care for adolescents from 12 to 17 years of age. This program contains 12 beds. The goal of the program is to provide comprehensive diagnostic services in order to establish long-term treatment goals. The program works to promote and develop good communication skills and to help the adolescents achieve a better understanding of self, family, and peers. Goals are established to provide and enhance the educational, interpersonal, and basic living and socialization skills that will improve the chances for successful adaptation for movement into a less restrictive environment.

- Geriatric Psychiatric Services Program provides diagnostic and therapeutic services of a medical and psychiatric nature to persons 65 years of age or older. These services are also available to adults under the age of 65 if found eligible through the Preadmission Screening and Resident Review (PASRR). Services are delivered in such a way as to give the patient maximum opportunity for fulfillment while residing in the least restrictive environment, including return to an appropriate community setting. This Medicare approved program has a bed capacity of 69.

- Intensive Treatment Unit (ITU) is a secure psychiatric unit for identified HSC patients and forensic court evaluation treatment cases referred by circuit court.

This unit provides a closer observation for patients who pose a high risk for harming themselves or others. ITU is a 15-bed unit that is structurally divided into two distinct areas. One area is designated for care of adolescents, the second area for care of adults.

- Chemical Dependency Treatment Services. The Adolescent Chemical Dependency Program is accredited by the Division of Alcohol and Drug Abuse as a 20-bed inpatient alcohol/drug treatment facility. Applicants must be 13-17 years of age and have a dependency diagnosis. The program is 60-120 days in length. Adolescents from this program attend an accredited Alternative School operated by HSC. The Adult Chemical Dependency program (Gateway) is based on the holistic approach of treatment utilizing the Twelve-Step Program of Alcoholics/Narcotics Anonymous. Integration with inpatient psychiatric treatment services has occurred, allowing for drug/alcohol treatment services to be provided to those individuals diagnosed with co-occurring mental health and drug and alcohol treatment disorders. The program is accredited by the Division of Alcohol and Drug Abuse as a 32-bed inpatient program.

South Dakota

Adult - Summary of Areas Previously Identified by State as Needing Attention

Adult - A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.

Summary of Areas Previously Identified as Needing Attention

As the DMH, and the Planning and Coordination Mental Health Advisory Council began discussions on plans/goals for the community mental health system, focus for transformation is on changing the philosophy driving services to be recovery-oriented. The Division of Mental Health, the Council of Mental Health Centers, the Clinical Management Team, and the Mental Health Planning Council have made a major commitment to transform the delivery of services to individuals and families in the public mental health system. The transformation initiative within the community mental health system for adults with severe and persistent mental illness involves strength-based, recovery-oriented services that are integrated for individuals with co-occurring disorders and disabilities. Included in these transformation services is responsiveness to individual needs/wants as well as cultural differences. The Division recognizes that these processes need to include state agencies, providers, clinicians, consumers, and families.

Through strategic planning, the Division of Mental Health (DMH) and the Mental Health Planning and Coordination Advisory Council identified needs and priorities for the community mental health system for FY08. The President's New Freedom Commission on Mental Health's final report drove the process of planning for ways to improve the system of care for individuals with mental illness. The goals identified as priority areas included the following:

- Goal 2: Mental Health Care is Consumer and Family Driven
  - 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
  - 2.2 Involve consumers and families fully in orienting the mental health system toward recovery.
- Goal 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice
  - 4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.

Significant Achievements during previous State Plan (FY08)

The following is a brief summary of some of the achievements during the previous State Plan.

- The Department of Human Services continues to follow the vision of CHOICES for all South Dakotans. CHOICES stands for Community, Hope, Opportunity, Independence, Careers, Empowerment, and Success**.** The Division of Mental Health collaborates with all Department of Human Services divisions in the delivery of person-directed services that are culturally competent and responsive to individual needs.
- In April 2008, the Advisory Council invited a National Association of Mental Health Planning and Advisory Council Councils (NAMHPAC) representative to South Dakota to educate Council members on roles, responsibilities, and advocacy as well as leadership development.
- In spring 2008, Advisory Council members and the Division of Mental Health held a special half-day meeting to discuss the Block Grant application.

Discussions included information on Block Grant requirements, Criterion included in the Block Grant, and current priorities, and recommendations for future activities to consider as a focus in transformation efforts.

- The Division of Mental Health is working with a newly formed consumer group in becoming an established consumer advocacy voice in South Dakota. This group, South Dakota United for Hope and Recovery, received technical assistance and training on "Finding Your Own Voce" from the National Empowerment Center in spring 2008. Discussions include building networks of support, peer supports, increasing advocacy efforts, and workforce development. The Division of Mental Health provided stipends in support of consumers attending this important workshop.
- The Division of Mental Health works closely with the Clinical Management Team (CMT) to further transformation efforts in community mental health services. The CMT is comprised of clinical directors from each community mental health center, Division staff, and consumers/family members. In all planning processes, the CMT follows the Vision Statement that was developed in 2006. This statement reads, "Recovery is an individualized process of being connected to others, satisfied with life and hopeful for the future." Focus is on ensuring consumers/family members continue to be involved at every level throughout the strategic planning processes related to implementing recovery-oriented, strength-based, and consumer driven services.
- The Division of Mental Health continues to utilize an accreditation review process of the eleven community mental health centers that emphasizes individualized planning, recovery, and provision of services in an integrated system of care. The Division of Mental Health and the CMT are working together to shift the concentration of accreditations to focus on incorporating the ten principles of recovery, including increased input from consumers/family members, development of integrated treatment for individuals with co-occurring disorders, and implementation of a continuous quality improvement process for services provided.
- The Division of Mental Health and the Division of Alcohol and Drug Abuse utilize a comprehensive, shared, management information system. The State Treatment and Reporting System (STARS) allows the Division to collect performance indicators on the national outcome measures. The Division has been working with the Clinical Management Team to review outcome measures and refine the performance indicators collected in STARS. Also included in this discussion is the development and implementation of evidence-based practices and performance indicators related to these practices.
- In March 2006, the Department of Human Services convened key stakeholders including consumers, providers, higher education, advocacy groups, tribal representatives, state government officials, and other interested parties to hold discussions on implementation of an integrated treatment model for individuals with co-occurring disorders and disabilities (CODD). Drs. Minkoff and Cline presented information on their Comprehensive, Continuous, Integrated System of Care (CCISC) model for designing statewide systems change to improve access and outcomes for individuals with co-occurring disorders. All stakeholders agreed

to adopt this model for the development of integrated treatment across the state. In the spring of 2007, the Mental Health Advisory Council and the State Alcohol and Drug Advisory Council held a joint meeting where discussions centered on the importance of involving both Councils in the development of integrated treatment. Subsequently, the Mental Health Advisory Council voted unanimously to add membership to the Council of an individual from the State Alcohol and Drug Abuse Advisory Council. This individual has attended all Mental Health Advisory Council meetings during the last year, and has been a key partner in continuing collaborative efforts with the Alcohol and Drug Advisory Council in the development of integrated treatment for individuals with co-occurring disorders.

- As transformation activities around integrated treatment continue, each community mental health center has identified staff within their agency to be Change Agents. These Change Agents are working to assist their respective agencies in providing more welcoming, accessible, integrated, continuous, and comprehensive services to individuals and families with co-occurring disorders. Change Agents have met three times as a statewide group over the last year with Drs. Minkoff and Cline, who are providing technical assistance in implementation of the CCISC model and development of plans on integration of services for individuals with co-occurring disorders. All community mental health centers have participated in on-site visits with Drs. Minkoff and Cline to provide technical assistance on integrated treatment development. In addition, a web discussion board is available to all Change Agents to increase networking availability of all stakeholders across the state.
- The Division of Mental Health participates in the Statewide Suicide Prevention Workgroup that created the statewide suicide prevention and intervention plan in 2004 for all individuals across the lifespan. Over the last year, there has been a revitalization of the Workgroup through meetings focusing on local level task forces building community partnerships and networks of support. In addition, through the SAMHSA State/Tribal Youth Suicide Intervention Grant activities, Applied Suicide Intervention Skills Training (ASIST) is provided to community caregivers and mental health providers to assist anyone that is experiencing suicidal thoughts. ASIST is a 2-day workshop designed to teach the skills necessary for interventions with individuals at risk of suicide. Developed by LivingWorks Education, Inc., the workshop prepares gatekeepers to integrate principles of intervention into everyday practice.

See Section II-Recent Significant Achievements for a more complete description of all significant achievements during the previous State Plan.

South Dakota

Adult - New Developments and Issues

Adult - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

There were no new developments or issues in the Adult mental health delivery system.

South Dakota

Adult - Legislative Initiatives and Changes

Adult - Legislative initiatives and changes, if any.

There were no legislative initiatives or changes from the previous State Plan.

South Dakota

Adult - Description of Regional Resources

Adult - A brief description of regional/sub- State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.

Regional Resources

Community Mental Health Centers (CMHCS)
Integral to South Dakota's community-based mental health delivery system are eleven private, non-profit community mental health centers. Each mental health center is governed by a local board of directors and each center has a specific geographic service area for which it has responsibility. See Attachment 3 for a map of community mental health catchment areas.

Behavior Management Systems (BMS) in Rapid City serves the western third of South Dakota. The counties included in the BMS catchment area are Bennett, Butte, Custer, Fall River, Harding, Jackson, Lawrence, Meade, Pennington, and Shannon counties. BMS services include an IMPACT (Individualized and Mobile Program of Assertive Community Treatment) program.

Capital Area Counseling Services, Inc. (CACS) is located in Pierre and serves central South Dakota. The counties that CACS covers are Buffalo, Haakon, Hughes, Hyde, Jones, Lyman, Stanley, and Sully. In addition to community mental health services, the agency is a core service agency for the provision of alcohol and drug abuse services through the Division of Alcohol and Drug Abuse. CACS also operates a therapeutic foster care program.

Community Counseling Services, Inc., (CCS) is located in east central South Dakota in Huron and covers a seven county area, including Beadle, Hand, Jerauld, Kingsbury, Lake, Miner, and Moody. CCS serves as a core agency for the provision of alcohol and drug abuse services through the Division of Alcohol and Drug Abuse. CCS services also include an IMPACT Program.

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Human Service Agency (HSA) in Watertown, in the east central part of South Dakota, serves a six county area. These counties include Clark, Codington, Deuel, Grant, Hamlin, and Roberts. HSA is an umbrella organization providing professional services to children and adults with mental illness, developmental disabilities, and alcohol and substance abuse issues. HSA also operates Serenity Hills, a residential program that serves individuals with co-occurring mental health and chemical dependency issues.

Lewis and Clark Behavioral Health Services (LCBHS) located in Yankton, in the extreme southeast portion of the State, provides services in seven counties including Bon Homme, Charles Mix, Clay, Douglas, Hutchinson, Union, and Yankton. LCBHS serves as a core agency for the provision of alcohol and drug abuse services through the Division of Alcohol and Drug Abuse. LCBHS services also include an IMPACT Program.

Northeastern Mental Health Center (NEMHC) in Aberdeen is located in the north central and northeast part of the State. It covers a large 10 county area, including Brown, Campbell, Day, Edmunds, Faulk, Marshall, McPherson, Potter, Spink, and Walworth counties. They also operate a therapeutic foster care program.

Southeastern Behavioral HealthCare (SEBHC) is located in Sioux Falls, in the southeastern part of the State. Counties included in the SEBHC service area are Lincoln, McCook, Minnehaha, and Turner. SEBHC Children's Center also serves children with developmental disabilities. SEBHC services include an IMPACT Program, and operation of an assisted living facility for adults with mental illness.

Southern Plains Behavioral Health Services (SPBHS) in Winner is located in rural south central South Dakota. It covers the counties of Gregory, Melette, Todd, and Tripp.

Three Rivers Mental Health and Chemical Dependency Center (TRMHCDC) is located in Lemmon, in the northwestern corner of South Dakota. This agency provides services in four counties: Corson, Dewey, Perkins, and Ziebach. TRMHCDC serves as a core agency for the provision of alcohol and drug abuse services through the Division of Alcohol and Drug Abuse.

These centers must meet administrative rules promulgated by the State Division of Mental Health and must include a comprehensive array of services to adults with severe and persistent mental illness (SPMI). Services provided are comprehensive, person-centered, and recovery focused, within an integrated system of care.

Continuous Assistance, Rehabilitation, and Education (CARE) Program services include:

* Case management
* Crisis assessment and intervention
* Liaison services
* Symptom assessment and management
* Medication prescription, administration, and monitoring
* Direct assistance
* Development of psychosocial skills
* Group Therapy
* Encouragement for active participation of family and supportive network

Other services available within community mental health centers include:

* Individualized and Mobile Programs of Assertive Community Treatment (IMPACT) in Yankton, Rapid City, Sioux Falls, and Huron
* Emergency services
* Programs for Assistance in the Transition from Homelessness (PATH) services
* A residential treatment facility for individuals with co-occurring mental health and substance abuse issues.
* Disaster related crisis counseling
* Transitional housing services
* Respite care for adults

Local Consumers & Family Supports

The National Alliance for the Mentally Ill-South Dakota (NAMI-SD) has nine affiliates across the State and boasts a statewide Consumer Council. NAMI-SD provides support at the local level through monthly meetings/support groups with local affiliates. Support groups are for persons who have a family member and for individuals who have a mental illness. NAMI-SD is currently training adults who are in recovery from a mental illness to be facilitators of NAMI Connection weekly support groups. NAMI's goal is to have 45-trained facilitators statewide by the end of 2008. In addition, NAMI-SD will be bringing the newest NAMI educational program, NAMI Basics, to South Dakota within the coming year. NAMI Basics is a family psychoeducation program for parents and other caregivers of children and adolescents living with mental illness.

The Division of Mental Health collaborates with NAMI- SD in providing information and articles for their bi-monthly newsletter, working with the "In Our Own Voice" Program to provide training and information to law enforcement and community groups, as well as providing conference call services for the Consumer Council to have monthly calls.

The Division of Mental Health also works with South Dakota Advocacy Services, whose mission is "To protect and advocate the rights of South Dakotans with disabilities through legal, administrative, and other remedies." This includes case consultations and advocacy efforts for individuals receiving services in the community mental health system.

Urban areas of the state have begun development of peer support programs to assist in the expansion of opportunities for successful recovery, shared growth, and wellness. These programs are in the early and less formal stages of development, but are able to offer support, socialization, and educational services on mental illness and stigma.

Provider Support and Technical Assistance

Council of Mental Health Centers All eleven community mental health center executive directors are members of the Council of Mental Health Centers. This organization meets monthly and employs an executive director. The Council, through its committee structure, and in close collaboration with the Division of Mental Health, provides review

and system improvement feedback on transformational activities associated with recovery and integrated treatment for the community mental health system. The Executive Director of the Council of Mental Health Centers also serves as the Executive Director of the Council of Alcohol and Drug Providers.

Clinical Management Team The Clinical Management Team (CMT) is comprised of clinical directors from each community mental health center, consumers, family members, and Division of Mental Health staff. The CMT is one of the driving forces involved in system transformation efforts related to recovery-oriented services and development of integrated treatment for individuals with co-occurring disorders.

Community Mental Health Education and Training
Community mental health centers (CMHCs) have their own internal budgets for education and training which have allowed CMHC staff opportunities to attend trainings and web-casts on important issues such as stigma, rural mental health, workforce development, recovery, and integrated treatment.

Integrated Treatment for Individuals with Co-occurring disorders
Drs. Minkoff and Cline are providing technical assistance in the development of integrated treatment for individuals with co-occurring disorders through use of the Comprehensive, Continuous, Integrated System of Care (CCISC) Model. All eleven CMHCs have completed the Co-morbid Program Audit Self Survey (COMPASS) and are developing Action Plans to address areas identified as needing improvement. Drs. Minkoff and Cline are visiting all eleven CMHCs to provide technical assistance on accomplishing goals related to the Action Plan.

State/Local Change Agents
The Division of Mental Health, the Division of Alcohol and Drug Abuse, the Human Services Center, and the Division of Developmental Disabilities have endorsed the Comprehensive, Continuous, Integrated System of Care (CCISC) model. The CCISC model principles align with the principles of recovery and will be instrumental in creating change at the grass roots level to implement the components of the model. Implementation includes providing culturally competent services in the following areas: consumer-driven planning; strength-based individual assessments; integrated treatment for individuals with co-occurring disorders, and recovery-oriented services that are provided in a welcoming, open manner.

As part of transformation activities associated with integrated treatment, each community mental health center has identified staff within their agency to be Change Agents. In the role of Change Agent, individuals function as a systems change leader, to help their respective agency, and the system as a whole, reorganize to provide more welcoming, accessible, integrated, continuous, and comprehensive services to individuals and families with co-occurring disorders. Change Agents have met three times as a group over the last year to begin discussions and develop plans on many of the issues with integration of services for individuals with co-occurring disorders.

Local Suicide Prevention
Suicide Tasks Forces are scattered throughout South Dakota communities. The current Garret Lee Smith/SAMHSA State Tribal Youth Prevention and Early Intervention Grant has supported existing task forces and helped create new groups where none existed. This is a valuable resource to the community as a whole as they offer education, advocacy and support to both individuals and family members of those at risk, those who have attempted suicide and those who have lost someone to suicide. The HELP!Line Center, located in Sioux Falls operates the National Suicide Prevention Lifeline (NSPL), 1-800-273-TALK. This toll-free crisis line is answered throughout S.D. by trained crisis workers at the HELP!Line Center.

State/Local Discharge Planning Collaborative Efforts
The Division of Mental Health and the Human Services Center, the State psychiatric hospital, are collaborating to build a seamless system of care as patients leave inpatient hospitalization and move to community-based services. A discharge planning workgroup comprised of individuals from the Division of Mental Health, the Human Services Center, and the community mental health center system work on streamlining the discharge planning process to ensure that all individuals, once discharged from the State hospital, are aware of and have immediate access to mental health services in the community.

Release Planners in the State correctional facilities collaborate with many community agencies, including mental health and alcohol/drug providers to facilitate improved discharge planning for individuals being released from the correctional facilities. All agencies work together on discharge plans to assist individuals being released to receive the mental health and/or alcohol/drug services needed, find employment, and locate acceptable housing, to assist them in successful transition to independent living in the community.

South Dakota

Adult - Description of State Agency's Leadership

Adult - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

Description of State Agency Leadership

The Department of Human Services (DHS), which oversees the Division of Mental Health (DMH), assists citizens of South Dakota in obtaining services and support in the following areas: substance abuse and prevention; developmental disabilities; mental health; vocational rehabilitation; and, services to the blind and visually impaired. The department's mission is to promote the highest level of independence for all individuals regardless of disability or disorder. DHS is committed to providing South Dakotans with CHOICES (Community-Hope-Opportunity-Independence-Careers- Empowerment-Success.

The DMH mission is to ensure children and adults with mental health disorders in our communities have the opportunity to choose and receive effective services needed to promote resiliency and recovery. In carrying out this mission, the Division of Mental Health provides a range of services through purchase of service agreements with eleven private, non-profit community mental health centers (CMHCs).

The DMH is invested in providing representation in task forces, workgroups, planning groups, and committees of other stakeholder groups, and actively collaborating with these stakeholders to assist in creating a system of care across agencies for individuals receiving community-based mental health services. This includes encouraging partnerships at the state, local, regional, and federal levels to support transformation activities and improvement of the community mental health system for South Dakota.

As discussed in the Description of Regional Resources, The DMH, the Division of Alcohol and Drug Abuse, the Human Services Center, and the Division of Developmental Disabilities are continuously collaborating to create a seamless system for those seeking/receiving services. These partnerships are instrumental in creating change at the local and regional levels to implement culturally competent services through development of an integrated system of care for adults, children, and families that is recovery-focused, strength-based, and consumer/family driven.

See Adult Plan, Section II, Service System Strengths and Weaknesses for accomplishments gained under current state leadership.

South Dakota

Child - Overview of State's Mental Health System

Child - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

Description of State Agency Leadership

See Adult Section I: Description of State Leadership for information. Also, see Child Plan, Service System Strengths and Weaknesses for accomplishments gained under current state leadership.

In addition to what is contained in the Adult Section, it is important to note the specific leadership role the Division of Mental Health took in systems of care development. The Division of Mental Health and the Clinical Management Team CMT) were instrumental in creating partnerships with other stakeholders in development of Systems of Care. The System of Care Steering Committee was originally created from a small group of CMT members. These CMT members worked diligently in involving other stakeholders and bringing them on board with systems of care development. These important stakeholders include the Department of Social Services, the Division of Alcohol and Drug Abuse, the Department of Corrections, the Department of Education, and the Unified Judicial System. The SoC Steering Committee membership has increased to include representation from all stakeholders listed. This committee developed the RFP for the SoC Pilot Project and is overseeing activities and goals related to the Pilot Project.

South Dakota

Child - Summary of Areas Previously Identified by State as Needing Attention

Child - A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.

Summary of Areas Previously Identified as Needing Attention

As the DMH, and the Planning and Coordination Advisory Council began discussions on plans/goals for the community mental health system, focus for transformation is on changing the philosophy of service delivery to a system of care approach. The Division of Mental Health, the Council of Mental Health Centers, the Clinical Management Team, and the Mental Health Planning Council have made a major commitment to transform the delivery of services to children and families in the public mental health system.

Transformation of the community mental health system for children with serious emotional disorders and their families includes providing culturally aware and competent services through development of systems of care including integrated treatment for children and families with co-occurring disorders.

Through strategic planning, the Division of Mental Health (DMH) and the Mental Health Planning and Coordination Advisory Council identified needs and priorities for the community mental health system for FY08. The President's New Freedom Commission on Mental Health's final report drove the process of planning for ways to improve the system of care for individuals with mental illness. The goals identified as priority areas included the following:

- Goal 2: Mental Health Care is Consumer and Family Driven
  - 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
  - 2.2 Involve consumers and families fully in orienting the mental health system toward recovery.
- Goal 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice
  - 4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.

Significant Achievements during previous State Plan (FY08)

The following is a brief summary of some of the achievements during the previous State Plan.

- The Department of Human Services continues to follow the vision of CHOICES for all South Dakotans. CHOICES stands for Community, Hope, Opportunity, Independence, Careers, Empowerment, and Success**.** The Division of Mental Health collaborates with all Department of Human Services divisions in the delivery of person-directed services that are culturally competent and responsive to individual needs.
- In April 2008, the Advisory Council invited a National Association of Mental Health Planning and Advisory Council Councils (NAMHPAC) representative to South Dakota to educate Council members on roles, responsibilities, and advocacy and leadership development.
- In spring 2008, Advisory Council members and the Division of Mental Health held a special half-day meeting to discuss the Block Grant application and use of WebBGAS. Discussions included information on Block Grant requirements, Criterion included in the Block Grant, and current priorities, and

recommendations for future activities to consider as a focus in transformation efforts.

- The Division of Mental Health works closely with the Clinical Management Team (CMT) to identify planning processes necessary for implementation of systems of care and family-driven, individualized services for children/families. The CMT is comprised of clinical directors from each of the eleven community mental health centers, consumers, and Division of Mental Health Staff.
- The Division of Mental Health continues to utilize an accreditation review process of the eleven community mental health centers that emphasizes individualized planning, recovery, and provision of services in an integrated system of care. The Division of Mental Health and the CMT are working together to shift the concentration of accreditations to focus on incorporating systems of care, including increased input from consumers/family members, development of integrated treatment for children and families with co-occurring disorders, and implementation of a continuous quality improvement process for services provided.
- The Division of Mental Health and the Division of Alcohol and Drug Abuse utilize a comprehensive, shared, management information system. The State Treatment and Reporting System (STARS) allows the Division to collect performance indicators on the national outcome measures. The Division has been working with the Clinical Management Team to review outcome measures and refine the performance indicators collected in STARS. Also included in this discussion is the development and implementation of evidence-based practices and performance indicators related to these practices.
- Integral to development of systems of care is the involvement and buy-in from all child/family serving agencies. A Children's System of Care Steering Committee, which includes representation from the Departments of Human Services, Social Services, Corrections, Education, and the Unified Judicial System, continues to engage in consensus building activities to develop a shared vision and strategic plan for designing, implementing, and evaluating the system of care infrastructure and services. As part of this process, community mental health centers applied to the Division of Mental Health for a System of Care Pilot Project Grant that would assist in the design, implementation, and evaluation of local systems of care. During FY08, The System of Care Pilot Project began at Behavior Management Systems in Rapid City. Western Interstate Commission for Higher Education (WICHE) is providing technical assistance to Behavior Management Systems, as well as the Children's System of Care Steering Committee in this project. Included in this process is a readiness assessment evaluation of the local community mental health center, development of local stakeholder relationships with other child-serving agencies, and increased involvement of children/families in the decision-making processes throughout systems of care development. All other community mental health centers across the state are encouraged to send staff to trainings and conferences held as part of this project, to start the process in other areas of the state as much as possible.
- The Unified Judicial System (UJS), Child Protective Services (CPS), the Department of Corrections (DOC), and the community mental health center

directors continue collaborative efforts to improve the referral and service delivery system for children who are referred by UJS or CPS to a community mental health center. Currently discussions are taking place to refine the Memorandum of Understanding between CPS and the community mental health centers to assist in furthering development of systems of care for children and families across the state.

- In March 2006, the Department of Human Services convened key stakeholders including consumers, providers, higher education, advocacy groups, tribal representatives, state government officials, and other interested parties to hold discussions on implementation of an integrated treatment model for individuals with co-occurring disorders and disabilities (CODD). Drs. Minkoff and Cline presented information on their Comprehensive, Continuous, Integrated System of Care (CCISC) model for designing statewide systems change to improve access and outcomes for individuals with co-occurring disorders. All stakeholders agreed to adopt this model for the development of integrated treatment across the state. In the spring of 2007, the Mental Health Advisory Council and the State Alcohol and Drug Advisory Council held a joint meeting with discussion centered on the importance of involving both Councils in the development of integrated treatment. Subsequently, the Mental Health Advisory Council voted unanimously to add membership to the Council of an individual from the State Alcohol and Drug Abuse Advisory Council. This individual has attended all Mental Health Advisory Council meetings during the last year, and has been a key partner in continuing collaborative efforts with the Alcohol and Drug Advisory Council in the development of integrated treatment for individuals with co-occurring disorders.
- As transformation activities around integrated treatment continue, each community mental health center has identified staff within their agency to be Change Agents, who are working to assist their respective agencies in providing more welcoming, accessible, integrated, continuous, and comprehensive services to individuals and families with co-occurring disorders. Change Agents have met three times as a group over the last year with Drs. Minkoff and Cline, who are providing technical assistance to Change Agents to implement the CCISC model and develop plans on integration of services for individuals with co-occurring disorders. All community mental health centers have participated in on-site visits with Drs. Minkoff and Cline to provide technical assistance on integrated treatment development. In addition, a web discussion board is available to all Change Agents to increase networking of all stakeholders across the state.
- The Division of Mental Health participates in the Statewide Suicide Prevention Workgroup that created the statewide suicide prevention and intervention plan for all individuals across the lifespan in 2004. Over the last year, there has been a revitalization of the Workgroup through meetings focusing on local level task forces building community partnerships and networks of support. In addition, through the SAMHSA State/Tribal Youth Suicide Intervention Grant activities, Applied Suicide Intervention Skills Training (ASIST) is provided to community caregivers and mental health providers to assist anyone that is experiencing suicidal thoughts. ASIST is a 2-day workshop designed to teach the skills

necessary for interventions with individuals at risk of suicide. Developed by LivingWorks Education, Inc., the workshop prepares gatekeepers to integrate principles of intervention into everyday practice.

See Table C-Description of Transformation Activities for more detailed descriptions of the SoC Pilot Project and the CCISC model.

South Dakota

Child - New Developments and Issues

Child - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

There were no new developments or issues in the children's mental health delivery system.

South Dakota

Child - Legislative Initiatives and Changes

Child - Legislative initiatives and changes, if any.

There were no legislative initiatives or changes from the previous State Plan.

South Dakota

Child - Description of Regional Resources

Child - A brief description of regional/sub- State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.

Regional Resources

Community Mental Health Centers

Integral to South Dakota's community-based mental health delivery system is eleven private, non-profit community mental health centers (CMHC). Each mental health center is governed by a local board of directors and each center has a specific geographic service area for which it has responsibility. See Attachment 3 for a map of community mental health catchment areas.

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extreme southeast portion of the State, provides services in seven counties including Bon Homme, Charles Mix, Clay, Douglas, Hutchinson, Union, and Yankton. LCBHS serves as a core agency for the provision of alcohol and drug abuse services through the Division of Alcohol and Drug Abuse. LCBHS services also include an IMPACT Program.

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Southeastern Behavioral HealthCare (SEBHC) is located in Sioux Falls, in the southeastern part of the State. Counties included in the SEBHC service area are Lincoln, McCook, Minnehaha, and Turner. SEBHC Children's Center also serves children with developmental disabilities. SEBHC services include an IMPACT Program and a Therapeutic Day Program for youth and families.

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These centers must meet administrative rules promulgated by the State Division of Mental Health and must include a comprehensive array of services to children with serious emotional disturbances (SED) and their families. Services provided are intensive and comprehensive, child-centered, family-focused, community-based, within an integrated system of care.

Children's Serious Emotional Disturbance (SED) Program services include:

* Case management
* Individual therapy
* Family education/support/therapy
* Crisis intervention
* Collateral contacts
* Assessment and evaluation
* Psychological evaluation
* Group therapy for children
* Parent/guardian group therapy
* Liaison services

Other services available include:

* Intensive Family Services-provided to families with children in out of home placements
* Emergency services
* Intensive Case Management Services (at nine CMHCs)
* Disaster related crisis counseling
* Respite care for children/families (funded through Division of Developmental Disabilties)

* PATH housing funds
* Therapeutic Day Treatment Services (two CMHC's)

See Child Plan, Section III, Criterion 1, Available Services for more information on the SED Program.

Local Consumers & Family Supports
The Division of Mental Health also works with South Dakota Advocacy Services, whose mission is "To protect and advocate the rights of South Dakotans with disabilities through legal, administrative, and other remedies." This includes case consultations and advocacy efforts for children/families receiving services in the community mental health system.

The National Alliance for the Mentally Ill-South Dakota (NAMI-SD) is interested in collaborating with parents and families to provide advocacy and support for children with serious emotional disturbances (SED). NAMI-SD recently introduced the Child and Adolescent Action Center (CAAC) to the Mental Health Planning and Advisory Council as an additional resource for parents and families of children with SED. Through promotion and awareness of the CAAC, NAMI-SD envisions offering more advocacy services and supports to South Dakota parents and families.

South Dakota families have been working to establish a family run organization for the advocacy of children and youth with mental health issues, and their families. The DMH helped to partner families with such experts as Barbra Huff to provide information and technical assistance in development of an organization. Currently, the parent of a child with a serious emotional disorder is working in parallel with Barbra Huff's activities to pull families together into an organized system of advocates for community based mental health services. While the formation of this important organization is in the early stages, its establishment, and leadership will help drive transformation in the State mental health system.

Once these family advocacy groups are established within the state, families of children with SED will have an improved opportunity to choose a support and advocacy organization that is best suited to their individual family needs. Having both opportunities available in the state will be an asset in the development and implementation of Systems of Care for children with SED and their families.

Provider Support and Technical Assistance
Council of Mental Health Centers All eleven community mental health center executive directors are members of the Council of Mental Health Centers. This organization meets monthly and employs an executive director. The Council, through its committee structure, and in close collaboration with the Division of Mental Health, provides review and system improvement feedback on transformational activities associated with the development of Systems of Care and integrated treatment for youth with co-occurring disorders.

Clinical Management Team The Clinical Management Team (CMT) is comprised of clinical directors from each community mental health center, consumers, family members, and Division of Mental Health staff. Family members are beginning to play a larger role, as the system realizes the need for the child/family voice at the table. The CMT is involved in system transformation efforts related to development of Systems of Care (SoC) and development of integrated treatment for individuals with co-occurring disorders. In addition, the Children's System of Care Steering Committee was formed to focus on integrating services for all child/family serving agencies. Representation on this Steering Committee includes the state Departments of Human Services, Social Services, Corrections, and Education, and the Unified Judicial System, as well as community mental health center staff.

Community mental health centers (CMHCs) have their own internal budgets for education and training which have allowed CMHC staff opportunities to attend trainings and web-casts on important issues such as development of strength-based child/family assessments, creation of child/family teams, workforce development, and implementation of child/family driven services.

Integrated Treatment for Individuals with Co-occurring disorders
Drs. Minkoff and Cline are providing technical assistance in the development of integrated treatment for individuals with co-occurring disorders through use of the Comprehensive, Continuous, Integrated System of Care (CCISC) Model. All eleven CMHCs have completed the Co-morbid Program Audit Self Survey (COMPASS) and are developing Action Plans to address areas identified as needing improvement. Drs. Minkoff and Cline are visiting all eleven CMHCs to provide technical assistance on accomplishing goals related to the Action Plan.

State/Local Change Agents
The Division of Mental Health, the Division of Alcohol and Drug Abuse, the Human Services Center, and the Division of Developmental Disabilities have endorsed the Comprehensive, Continuous, Integrated System of Care (CCISC) model. The CCISC model principles align with the principles of recovery and will be instrumental in creating change at the grass roots level to implement the components of the model. Implementation includes providing culturally competent services in the following areas: consumer-driven planning; strength-based individual assessments; integrated treatment for individuals with co-occurring disorders, and recovery-oriented services that are provided in a welcoming, open manner.

As part of transformation activities associated with integrated treatment, each community mental health center has identified staff within their agency to be Change Agents. In the role of Change Agent, individuals function as a systems change leader to help their respective agency, and the system as a whole, reorganize to provide more welcoming, accessible, integrated, continuous, and comprehensive services to individuals and families with co-occurring disorders. Change Agents have met three times as a group over the last year to begin discussions and develop plans on many of the issues with integration of services for individuals with co-occurring disorders.

Local Suicide Prevention
Suicide Tasks Forces are scattered throughout South Dakota communities. The current Garret Lee Smith/SAMHSA State Tribal Youth Prevention and Early Intervention Grant has supported existing task forces and helped create new groups where none existed. This is a valuable resource to the community as a whole as they offer education, advocacy, and support to both individuals and family members to those at risk, those who have attempted suicide, and those who have lost someone to suicide. Community Suicide Task Forces are linked to resources and other Task Forces through the South Dakota Suicide Prevention Website (sdsuicideprevention.org) and through involvement with the Statewide Strategy for Suicide Prevention Workgroup. The HELP!Line Center, located in Sioux Falls operates the National Suicide Prevention Lifeline (NSPL), 1-800-273-TALK. This toll-free crisis line is answered throughout S.D. by trained crisis workers at the HELP!Line Center.

Discharge Planning-Human Services Center and Juvenile Corrections Facility
The Division of Mental Health and the Human Services Center, the State psychiatric hospital, are collaborating to build a seamless system of care as patients leave inpatient hospitalization and move to community-based services. A discharge planning workgroup comprised of individuals from the Division of Mental Health, the Human Services Center, and the community mental health center system works together on streamlining the discharge planning process to ensure that all individuals, once discharged from the State hospital, are aware of and have immediate access to mental health services in the community.

The Division of Mental Health in cooperation with the Division of Alcohol and Drug Abuse and the Department of Juvenile Corrections conduct a joint transition/discharge process that assist youth in referrals for mental health and alcohol/drug services in their home community prior to discharge from STAR Academy, a DOC facility for juveniles. This process allows better identification of specific services the youth will need to remain in their home community.

South Dakota

Child - Description of State Agency's Leadership

Child - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

Description of State Agency Leadership

See Adult Section I: Description of State Leadership for information. Also, see Child Plan, Service System Strengths and Weaknesses for accomplishments gained under current state leadership.

In addition to what is contained in the Adult Section, it is important to note the specific leadership role the Division of Mental Health took in systems of care development. The Division of Mental Health and the Clinical Management Team CMT) were instrumental in creating partnerships with other stakeholders in development of Systems of Care. The System of Care Steering Committee was originally created from a small group of CMT members. These CMT members worked diligently in involving other stakeholders and bringing them on board with systems of care development. These important stakeholders include the Department of Social Services, the Division of Alcohol and Drug Abuse, the Department of Corrections, the Department of Education, and the Unified Judicial System, and family partners. The SoC Steering Committee membership has increased to include representation from all stakeholders listed. This committee developed the RFP for the SoC Pilot Project and is overseeing activities and goals related to the Pilot Project.

South Dakota

Adult - Service System's Strengths and Weaknesses

Adult - A discussion of the strengths and weaknesses of the service system.

Strength and Weaknesses of the Service System

As the Division of Mental Health (DMH) and the Planning and Coordination Advisory Council hold discussions on plans/goals for the community mental health system, focus for transformation is on changing the philosophy driving services to be recovery-oriented and integrated for individuals with co-occurring disorders. The President's New Freedom Commission on Mental Health's final report drove the process of planning for ways to improve the system of care for individuals with mental illness. As part of the discussion, we focused on strengths and weaknesses of the system that fall in line with the goals and recommendations of the New Freedom Commissions final report.

Goal 1: Americans Understand that Mental Health is essential to Overall Health

Strengths

Suicide Awareness Project

The DMH was fortunate in securing a three year, SAMHSA- State/Tribal Youth Suicide Prevention and Early Intervention Grant. This grant was written based on the South Dakota Strategy for Suicide Prevention, which provides a public health approach to suicide prevention and intervention. This poses an opportunity to impact the State's high rate of suicide by targeting 14-24 year olds through high school and university education, training, and awareness activities. Grant activities include providing training on Suicide Prevention Skills, implementing curriculum in high school classes focused on building suicide prevention skills in youth, and collaborating with local suicide task forces to build local/regional networks of support to improve the early intervention, referral, and follow-up process.

Primary Mental Health Care Project: Supporting the Development of Best Practice for Depression Treatment in South Dakota Primary Care Settings

Recently, the South Dakota Governor's Healthcare Commission identified improving the ability of primary care providers to meet the needs of their patients with mental health care needs as a high priority. As a result, the Division of Mental Health applied for and received a Wellmark Foundation Grant to address treatment of depression by primary care physicians. This was a collaborative effort between DMH, the Governor's Health Care Commission- Sub-Committee on Mental Illness and Depression, the South Dakota Council for Mental Health Centers, community mental health center representatives, Horizon Health Care Inc. (a system of nine community based primary care clinics), and Western Interstate Commission for Higher Education (WICHE). Included in the grant activities were trainings for primary care and mental health providers at the nine community health centers. The MacArthur program for identifying and treating depression in primary care was utilized and includes incorporation of screening instruments and protocols for scoring and conveying this information to treating physicians within their practices; and, assisting patients who screen positive for depression in following a treatment path they choose.

Indigent Medication Program
The DMH has worked to develop a seamless system so that consumers and families are not left without medications because of funding restrictions. The DMH works with consumers who receive Medicare Part D to provide medication funding assistance when they reach the "donut hole" period where they become responsible for the full cost of their medications. More information on the Indigent Medication Program can be found in Adult Plan, Criterion One, Available Services.

Staffing and Resources
Community based mental health administration within the Division of Mental Health is accomplished with only eight staff members. Even with the relatively small staff, the Division of Mental Health has been successful in securing competitive grants to assist in transformation of the community based mental health system. Such grants include the Primary Care Grant and the State/Tribal Youth Suicide Prevention and Intervention Grant.

Continuous Quality Improvement
The Division of Mental Health, the community mental health centers, and the Advisory Council all recognize and include the development of ongoing quality improvement (QI) efforts that continue throughout implementation of transformational activities and beyond. The focus of transformation activities over the last year has been on increasing the consumer/family voice in planning and policy decision-making. In addition, community mental health centers are beginning to develop "welcoming policies" that promote recovery, consumer/family driven treatment, and integrated treatment for individuals with co-occurring disorders throughout the community mental health system.

Weaknesses
Funding
Lack of additional funding and continued decreases in Block Grant funding make it difficult to support the development of a recovery-oriented community mental health system that includes integrated treatment for individuals with co-occurring disorders. This has slowed the transformational process in our state. In addition, much of the State's funding for transformation activities remains fragmented, as each State agency (Department of Corrections, Unified Judicial System, Department of Education, Department of Social Services, and the Division of Alcohol and Drug Abuse) within their own budget structure without flexible or blended funding options for transformation activities and services.

Stigma
Stigma remains an issue in the delivery of mental health services across the state. The loss of anonymity when seeking services combined with the tendency to stereotype mental health services creates a barrier for those who are in need of such services. This is especially true in rural areas where fewer service and support options exist. Although accessibility in a rural state will always be an issue, the Division of Mental Health is working closely with the Advisory Council and community mental health centers to battle the stigma of mental illness and receiving mental health services.

Goal 2: Mental Health Care is Consumer and Family Driven

Strengths

Individualized, Person-Centered, Family Driven Planning

The DMH consulted with the Depression and Bipolar Support Alliance (DBSA), in conjunction with the National Association of State Mental Health Program Directors (NASMHPD) National Technical Assistance Center, and with Support from SAMHSA's Center for Mental health Services to sponsor a Transformation, Recovery, and Peer-Support Institute (TRPSI). This consumer-run institute took place in fall of 2007 as part of the annual South Dakota NAMI conference. South Dakota consumers, family members, and community mental health providers were given the opportunity to come together to build plans to make recovery real in South Dakota.

The Division of Mental Health works closely with the Clinical Management Team (CMT) to further transformation community mental health services. The Adult Sub-Group of the CMT is comprised of clinical directors from each community mental health center, Division staff, and consumers. In all planning processes, the CMT follows the Vision Statement that was developed in 2006. This statement reads, "Recovery is an individualized process of being connected to others, satisfied with life and hopeful for the future." The primary focus for all transformation activities is ensuring consumers/family members are involved at every level throughout the strategic planning processes related to strengthening recovery-oriented, strength-based, consumer driven services. The Adult subgroup has also started working on the development of performance measures around outcomes of services. This includes the development of core competencies for staff providing mental health services in a recovery oriented, strength-based, consumer driven integrated system of care. The feedback gathered from consumers is a critical piece in the process of system change. The Division of Mental Health is assisting in the promotion of recovery in the following areas:

- Sponsoring monthly statewide consumer conference calls focusing on recovery and consumer driven services.
- Collaborating with providers and consumers through involvement on the Clinical Management team to continue activities related to development of recovery-oriented treatment plans and individualized services.
- Enhanced accreditation process that promotes a recovery focused, integrated system of care, including services for individuals with co-occurring disorders.

The DMH and the Mental Health Planning and Coordination Advisory Council collaborate to identify system needs and set future priorities for the community based mental health system. The Mental Health Advisory Council provides valuable input into the development of goals and objectives related to the transformation efforts around the initiatives for integrated treatment and recovery-oriented services for adults. They bring a unique perspective to discussions as they share personal experiences about the positives and negatives they encounter within the current service delivery model. The consumer

and family members on the council also advocate for their peers, sharing the stories and concerns of other consumers and families so that the system might improve and appropriate goals are addressed. The DMH and the Advisory Council have developed a very close working relationship, recognizing the importance of stakeholder involvement in strategic planning processes. The Advisory Council is involved in the development of all goals and objectives for the CMHS Block Grant and provides ongoing feedback to the Division of Mental Health regarding issues related to service delivery within the community-based mental health system. During the last year, Advisory Council members participated in a training workshop provided by the National Association of Mental Health Planning and Advisory Councils. This workshop provided valuable information to Planning Council members on the Block Grant, the importance of monitoring community mental health services, and how to improve advocacy efforts across the state for individuals with mental illness.

Consumer/Family Involvement in Planning, Evaluation and Services

Representation on the Planning and Advisory Council, Consumer Council and Clinical Management Team, gives consumers and family members the opportunity to share their ideas on development, implementation and evaluation of the transformational activities in our State. In addition, consumers and family members participate on workgroups that are focusing on development of systems of care, implementation of evidence-based practices, and development of performance indicators relative to recovery and consumer driven services. In Section II- States Vision for the Future, it is clear that consumer and family involvement will be ongoing with plans for expansion on future projects.

Employment

To assist consumers with their employment goals, the Division of Rehabilitation Services (DRS) funds a program called "Employment Skills Program". The Employment Skills Program provides the individual the opportunity to try various employment occupations, develop work skills and increase stamina. DRS also purchases the services from community mental health centers to provide job development and job supports at the employment placement. The placement and services are coordinated with the community mental health centers to help assure the success of employment.

Seclusion and Restraints

Over the past six years, the Human Services Center has been very successful in reducing the number of seclusion and restraints used within the hospital. This has been accomplished through continuous trainings on non-violent crisis intervention for all direct patient staff at the Human Services Center and changing the philosophy of the hospital to a recovery-oriented, partnership with patients and family members.

Correctional Facilities

Release Planners in the correctional facilities continuously work with various community agencies including community mental health centers and alcohol drug providers in efforts to improve the development of appropriate release plans when paroling an individual with a mental illness from a correctional facility. Community agencies collaborate with the Release Planners to ensure individuals are able to access needed mental health

services/substance abuse services within the community as well as assisting to find community resources such as housing, employment, and other necessary connections to create a successful transition into the community.

Weaknesses

Lack of Affordable Housing

There continues to be a shortage of housing opportunities for consumers within the state. For individuals that have criminal backgrounds and are in need of mental health services, many of the housing options are very limited. In addition, many communities lack the low income housing and/or supervised living options for individuals who cannot live independently. Assisting individuals with finding appropriate housing options poses many issues for our community mental health providers.

Consumer Driven Supports

The combination of poverty and remoteness facing rural areas presents many challenges in offering a full array of services such as consumer-run peer support groups.

Goal 3: Disparities in Mental Health Care are Eliminated

Strengths

Rural Mental Health Care Access

Many community mental health centers have established satellite offices in smaller communities to improve access to services. In addition, creative funding has improved access to mental health care in rural areas through development of a rural rate and Medicaid reimbursement for tele-pyschiatry services. The rural rate helps to support the State's vision of providing services in the home community or most appropriate setting.

Weaknesses

Cultural Competency

Disparities in culturally competent mental health services exist. The Division of Mental Health works to integrate cultural awareness and competency into all transformation activities. The Division of Mental Health works closely with the Advisory Council and community mental health centers to identify cultural competence needs so that individuals receiving mental health services can be served appropriately based on their unique needs.

Rural Needs

Rural areas also suffer from a shortage of mental health providers, particularly psychiatrists. Rural areas have difficulty recruiting and retaining these professionals as low salaries and rural living often are not attractive when compared to other competitive market areas.

Goal 4: Early Mental Health Screening, Assessment and Referral to Services is Common Practice

Strengths

Early Identification and Referral Efforts

The State/Tribal Youth Suicide Prevention and Intervention Grant is providing support in the development of early identification and referral processes at two state universities for students who are at risk of suicide. Grant activities include training for resident assistants and staff of the two university's Counseling Departments to identify and refer students at-risk. Over the last year, the statewide Suicide Prevention Workgroup has held meetings focusing on local level task forces building community partnerships and networks of support to aid in the early identification and referral efforts for persons at risk of suicidal behavior.

The Primary Care Grant activities included utilization of depression screening tools that assisted in increasing the identification and referral to mental health services for individuals seen through primary care physicians. In addition, it raised the awareness of mental health issues for primary physicians to be concerned with as they are seeing patients on a daily basis.

Integrating Co-occurring Disorders and Disabilities (CODD) Services

The DMH and The Division of Alcohol and Drug Abuse continue to collaborate to support a residential program providing services to individuals with co-occurring disorders. The Serenity Hills Program (operated through a core mental health/substance abuse provider), is a custodial care facility for adults who are diagnosed with both mental health and substance abuse disorders. It uses a multidisciplinary "integrated" model that combines both mental health and substance abuse treatment within a single, unified, and comprehensive program.

The Division of Mental Health and the Division of Alcohol and Drug Abuse also collaborate to provide an Intensive Methamphetamine Treatment Program (IMT) to women inmates at the State Women's Correctional Facility. The IMT program is a 14-15 month, four-phase chemical dependency program for offenders who have been diagnosed as having a dependency or addiction to methamphetamine and who have been recommended to participate in the IMT program by chemical dependency staff. This program includes integrated substance abuse/mental health services provided to the women while in prison and once paroled to the community.

Stakeholders across the state have come together through a co-occurring initiative to adopt the Comprehensive, Continuous, Integrated System of Care (CCISC) model. Through a SAMHSA Grant for Treatment of Persons with Co-Occurring Disorders, the Division of Mental Health works closely with the Division of Alcohol and Drug Abuse to integrate services for individuals with co-occurring mental health and substance abuse issues. All stakeholders involved have agreed on the importance of building a system for co-occurring disorders and have committed resources to help improve services to

individuals with co-occurring disorders. Every community mental health center and alcohol/drug provider across the state has received on-site technical assistance (TA) on the Co-morbid Program Audit Self Survey (COMPASS) to assess program competencies and assist in the implementation of the CCISC model. Mental Health and Alcohol and Drug Providers are now developing action plans to implement integrated treatment throughout the service systems. In addition, community mental health centers and alcohol and drug providers are developing screening tools and being encouraged to implement. See Table C: Description of Transformation Activities for more detailed information on the CCISC model.

Weaknesses

Stigma

Stigma in South Dakota creates a challenge in early detection of mental health disorders through screening and assessments as individuals are reluctant to seek mental health services and often go undetected in primary care settings.

Goal 5: Excellent Mental Health Care is Delivered and Research is Accelerated

Strengths

Evidence Based Practices

The DMH is working with the four Assertive Community Treatment (ACT) programs within the state to ensure programs are meeting fidelity to the ACT model. Included in this process is the development of performance measures and outcomes that are recovery-oriented in nature, specifically around employment, living situation, and criminal justice involvement. Over the last year, the ACT programs and the Division of Mental Health have collaborated on development of outcome measure tools that look at change in employment, living situation, criminal justice involvement, substance abuse issues, and number of psychiatric hospitalizations. In addition, ACT consumers are asked twice a year to complete a survey focusing on their individual needs/wants, quality of services, and areas of concern that may need to be added to the treatment plan. The Division is also continuing to explore the feasibility of implementing other SAMHSA toolkits, specifically the Illness Management and Recovery and the Family Psychoeducation Toolkits.

Weaknesses

Workforce

As South Dakota moves forward with systems transformation more workforce training is needed to ensure the full opportunity for recovery and wellness for individuals with mental illness. Lack of additional funding and continued decreases in Block Grant funding make it more difficult to address workforce issues. Many community mental health centers have presented joint trainings and utilize inter-agency technical assistance, but without formal funding and infrastructure, the process is slow. There is also a shortage of qualified professionals to work in the community mental health centers. Individuals entering the community based mental health system directly from higher education often times do not have the training to provide community-based, recovery oriented services to adults with severe and persistent mental illness and many have not

been introduced to the co-occurring, integrated treatment model or to working within a system of care. Further, psychiatry services in the rural and frontier areas of the state pose a significant challenge to providing a broad continuum of care. Often psychiatrists are not willing to live and work in these rural and frontier areas, and contracting with those who are willing is very expensive for mental health providers. Overall, competing agencies and private practice create a climate where competitive salaries are an issue. Combine this with the rural layout of the State and recruitment and retention become hard issues to deal with in some areas of the state.

Goal 6: Technology is used to Access Mental Health Care and Information

Strengths

Management Information System

The Division of Mental Health and the Division of Alcohol and Drug Abuse utilize a comprehensive, shared, management information system. The State Treatment and Reporting System (STARS) allows the Division of Mental Health to collect performance indicators on the national outcome measures. In addition, the Division has been working with the Clinical Management Team to review outcome measures and refine the performance indicators collected in STARS. Performance indicators include point-in-time measurements of criminal justice involvement, living arrangement, and employment status. Also included in this discussion is the development and implementation of evidence-based practices and performance indicators related to these practices.

Weakness

Expansion of Tele-psychiatry Services

The DMH has implemented Tele-psychiatry Service as stated above in Goal 3 strengths. However, as many rural communities lack the equipment or resources to purchase the equipment necessary to implement this useful tool, expanding this program has been difficult.

South Dakota

Adult - Unmet Service Needs

Adult - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

Unmet Needs

The Division of Mental Health, the Mental Health Advisory Council, and the community mental health centers have worked together to recognize unmet needs and service gaps across the community mental health system. Below are brief descriptions organized by area of need.

Training And Consumer Advocacy

Lack of additional funding and continued decreases in Block Grant funding make it difficult to provide consumers and providers the necessary technical assistance and training opportunities on recovery-oriented, strength-based, consumer driven services. Important recovery components such as peer support specialists and consumer-based advocacy organizations need to be included in transformation activities.

Although community mental health centers have endorsed implementation of the Comprehensive, Continuous, Integrated System of Care (CCISC) Model of integrated treatment for individuals with co-occurring disorders, there remains a need for additional training and technical assistance on implementation of integrated services for individuals. These trainings include development of action plans for implementation, creation of screening and assessment tools, conducting integrated strength-based assessments, and development of policies and procedures on welcoming, integrated services for individuals with co-occurring disorders.

Additionally, there is a gap between higher education and the community mental health system. Professionals entering the community-based mental health system have not received training on recovery-oriented, strength-based, consumer driven services to adults with severe and persistent mental illness. The Division of Mental Health needs to continue collaborative efforts with higher education institutions to include important transformation activities in curriculums taught in colleges and universities.

Evidence-Based Practices, Data Collection, and Research

The majority of South Dakota is rural/frontier, with scarce resources, isolation, and transportation difficulties posing challenges with the implementation of evidence-based practices consistently across the state. Despite these barriers, the Division of Mental Health, the Advisory Council, and community mental health centers recognize the importance of further developing evidence-based practices, especially around illness management and recovery, and family psychoeducation. Furthermore, the Division of Mental Health and the community mental health system do not currently have data infrastructure in place to conduct point-in-time measurements for important performance indicators relative to recovery. These indicators include such measurements as change in living situation, criminal justice involvement, improved functioning, and social connectedness.

Access to Services and Workforce Development

Access to services throughout South Dakota remains an important issue, but especially in the very rural/frontier areas of the state. Many of the community mental health centers have large catchment areas that encompass great distances. Mental Health providers in

South Dakota have difficulty recruiting and retaining an adequate number of psychiatrists and mental health care professionals in rural/frontier areas. Complicating this issue is the lack of public transportation for individuals without reliable transportation to reach services. Additionally, the time and cost involved in providing services to geographically remote areas contributes to workforce issues. These barriers sometimes result in individuals being placed on waiting lists, and/or having to travel long distances to receive services.

South Dakota

Adult - Plans to Address Unmet Needs

Adult - A statement of the State's priorities and plans to address unmet needs.

Priorities and Plans to Address Unmet Needs

The Division of Mental Health and the Mental Health Planning Council have made a major commitment to transform the delivery of services to individuals and families in the public mental health system. Transformation of the community mental health system for adults with severe and persistent mental illness development of recovery-oriented services that are strength-based and consumer driven, and integrated treatment for individuals with co-occurring disorders. Included throughout transformation activities is provision of services that are culturally aware and competent.

As identified by the Advisory Council, the President's New Freedom Commission Goals and Recommendations that are integral to transformation activities in South Dakota are as follows:

- Goal 2: Mental Health is Consumer and Family Driven
  - 2.1 Develop an individualized plan of care for every adult with a serious mental illness
  - 2.2 Involve consumers and families fully in orienting the mental health system toward recovery
- Goal 4: Early Mental Health Screening, Assessment, and Referral to Services are common practice
  - 4.4 Screen for co-occurring mental health and substance use disorders and link with integrated treatment strategies.
- Goal 5: Excellent Mental Health Care is Delivered and Research is Accelerated
  - 5.3 Improve and expand the workforce providing evidence-based mental health services and supports.

Many of these priorities will require multiple years to implement as described throughout this Block Grant Application. The following list of priorities and plans are broken out according to the categories listed in the Unmet Needs Section.

<u>Training</u>

The Division of Mental Health secured funding through the National Association of State Mental Health Program Directors National Technical Assistance Center, and with support from SAMHSA's Center for Mental health Services, to provide consultation on peer support and recovery. The Depression and BiPolar Support Alliance provided a Transformation, Recovery, and Peer-Support Institute that took place as part of the annual South Dakota National Alliance for Mental Illness (NAMI) conference in fall 2007. This Institute provided a form for consumers, family members, and mental health providers to gather and learn from each other's unique perspectives.

Through stipends for consumers to attend a kickoff meeting, the Division of Mental Health is supporting grass roots efforts in developing a statewide Consumer Advocacy Agency. The Division of Mental Health supports the statewide development of South Dakota United for Hope and Recovery (SDUnited, for short). From this meeting, SDUnited developed a planning committee and a vision statement, "We are working together with dignity and respect as able human beings, to recover an equal place as full

citizens in society, setting an example for others of empowerment and hope." The Division of Mental Health will continue to encourage and support this Consumer Group in growing to its fullest potential.

Plans for future trainings include collaboration with consumers to invite the National Empowerment Center to South Dakota to provide both consumers and providers additional technical assistance on development of recovery-oriented, strength-based mental health services. In addition, the Division of Mental Health will continue to explore other opportunities that assist consumers, family members, and providers in further building recovery-oriented services across the State of South Dakota.

The Division of Mental Health, the Division of Alcohol and Drug Abuse, and the Human Services Center have partnered with providers in a statewide quality improvement process using the Comprehensive, Continuous, Integrated Systems of Care (CCISC) Model as a framework for engaging every program in becoming a welcoming, recovery oriented co-occurring disorder capable program, and every clinical staff person in developing welcoming, co-occurring disorder competency. Activities to date have included development of a charter document, readiness assessments of mental health and alcohol/drug providers, creation of Change Agent positions within each community mental health center and alcohol and drug provider, and preparation for implementation of action plans. This project has received a major boost when South Dakota was awarded the COSIG Grant at the beginning of FY08. The grant has provided the resources necessary at both the state and agency levels to support efforts in development of the core infrastructure for integrated treatment. Planned activities over the next three years include continued onsite technical assistance to providers, training on integrated, strength-based assessments, development of screening and assessment tools, training on SAMHSA's TIP 42, and development of billing structures and core competencies/scopes of practice on integrated treatment for individuals with co-occurring disorders. See Table C: Description of Transformation Activities for more information on implementation of the CCISC model and development of integrated treatment.

As part of the State/Tribal Youth Suicide Prevention and Intervention Grant, the Division, in partnership with Sinte Gleska University and Wakanyeja Pawicayapi, Inc., continues to offer cultural awareness training to all mental health providers, specifically on Lakota culture and beliefs. These trainings assist community mental health centers in incorporating cultural sensitivity into the services provided to consumers. Over 15 Cultural awareness trainings have taken place within the last 2 years, with an additional 15 planned during the next year. The Division of Mental Health, the Mental Health Advisory Council, and the Clinical Management Team will continue to explore training and technical assistance opportunities toward improving cultural awareness and competency across the mental health system.

Evidence-Based Practices, Improved Data Collection, and Research

Through funds awarded as part of a SAMHSA Data Infrastructure Grant, the Division of Mental Health will continue to work closely with the Clinical Management Team to implement the Substance Abuse and Mental Health Services Administration (SAMHSA)

toolkits on Illness Management and Recovery and Family Psycho-Education. Furthermore, the Division of Mental Health and the CMT are collaborating to develop the capability to provide various point-in-time measurements for living situation and employment performance indicators, as well as the capability to report client level data relative to outcomes associated with social connectedness, improved functioning, and criminal justice involvement.

In FY05, the Division, with input from the Advisory Council and the Clinical Management Team (CMT), began implementation of an enhanced accreditation review process of the eleven community mental health centers. This process moved from a strictly documentation compliance process to one that is more strength-based and focused on individualized planning and recovery. The accreditation process provides feedback and technical assistance opportunities for community mental health centers to develop continuous quality improvement processes that move forward the implementation of recovery-oriented services for all individuals with mental illness, including those with co-occurring disorders. Plans include further development of consumer/family involvement in the accreditation process, and refinement of process to include more focus on identification and treatment for individuals with co-occurring disorders.

Access to Services and Workforce Development

The Division will continue to allow community mental health centers in the most rural/frontier areas to utilize a reimbursement rate for all services provided that is 20% higher than the regular rate for services. Tele-psychiatry reimbursement through Medicaid will also continue to play a vital role in ensuring access to services in the most rural areas.

Through a Wellmark Foundation Grant, the Division of Mental Health in collaboration the Governor's Health Care Commission- Sub-Committee on Mental Illness and Depression, the South Dakota Council for Mental Health Centers, community mental health center representatives, Horizon Health Care Inc. (a system of nine community based primary care clinics), and Western Interstate Commission for Higher Education (WICHE) collaborated to address screening and treatment of depression by primary care physicians. Grant activities sought to demonstrate improved depression screening and follow-up care in primary care settings through a pilot project with nine community health clinics in central and south central South Dakota. The Division of Mental Health will continue working with the Advisory Council and community mental health centers to improve collaboration between mental health and primary care providers. In addition, the Division will remain an important participant with the Governor's Health Care Commission Sub-Committee on Mental Illness and Depression to further the knowledge base of primary care physicians on mental health issues. These important partnerships will assist in addressing barriers that exist for individuals accessing mental health services.

The Division of Mental Health will continue to work with community mental health centers to provide additional trainings and technical assistance opportunities in the areas of integrated treatment for co-occurring disorders and recovery –oriented services as we

work to bridge the gap between higher education and workforce readiness. Community mental health centers will continue to offer college students opportunities for internships within the community mental health system. This affords students the opportunity to learn first hand about providing strength-based and consumer driven services in an integrated system of care.

South Dakota

Adult - Recent Significant Achievements

Adult - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

Recent Significant Achievements

The Division of Mental Health continues to collaborate with the Mental Health Advisory Council, community mental health centers, and consumers and families in making progress toward development of a recovery-oriented, strength-based, consumer-driven, and integrated system of care for adults receiving services through the community-based mental health system. In addition to the significant achievements outlined in Section II Adult – Summary of Areas Previously Identified as Needing Attention, there are many other significant areas of achievements to highlight.

Mental Health Planning and Advisory Council
Education and training have played an important role in ensuring Advisory Council members receive information on various topics associated with the community mental health system. Education and training have also allowed advisory council members to begin to develop important leadership and advocacy skills. In April 2008, a National Association of Mental Health Planning Councils (NAMHPAC) representative presented information to assist South Dakota Advisory Council members in developing a better understanding of the roles, responsibilities, and possibilities of the Advisory Council. The overall goal of the workshop was to improve the services delivered to persons living with mental disorders by improving the planning, evaluation, and monitoring of these services by stakeholders, and reinforcing the importance of consumers, parents, and family members being true partners in the planning and oversight of mental health services.

Advisory Council members held a special half-day meeting to discuss the Block Grant application. During the meeting, discussion revolved around development of priorities for the next few years, and the Advisory Council made recommendations to consider as a focus in our transformation efforts (Adult Plan-Plans to Address Unmet Needs for goals and recommendations). Some additional examples of presentations held during council meetings include:

- Presentations from consumers and family members providing perspectives of living with mental illnesses and recovering;
- Discussions led by Indian Health Services on mental health issues facing the Native American population, specifically on availability of mental health professionals;
- Information shared on development of integrated treatment for individuals with co-occurring mental health and substance use issues. This included creation of a joint representative position to serve on both the Mental Health and the Alcohol and Drug Advisory Councils. Creation of this position has assisted in ensuring information is shared across Councils and helped to increase the collaborative efforts toward development of an integrated system of care.

Clinical Management Team
The Clinical Management Team, which includes representation from the Division of Mental Health, clinical directors of community mental health centers, and consumers/family members has been one of the major driving forces involved in system

transformation efforts related to recovery-oriented services and development of integrated treatment for individuals with co-occurring disorders. As part of transformation activities and recommendations made by the Clinical Management Team, the Division of Mental Health has implemented an accreditation review process of the eleven community mental health centers that emphasizes individualized planning, recovery, and provision of services in an integrated system of care. This includes encouragement of centers to involve direct service clinicians in the process, as well as provides a framework for discussions on transformation, recovery, and integrated treatment. Components of the accreditation process include:

- Life quality interviews with consumers/families and "shadowing" of sessions.
- Chart reviews consisting of random chart pulls as well as quality service delivery by the centers.
- Involvement of community mental health center staff as reviewers. These individuals are direct service clinicians from other community mental health centers, who assist with chart reviews, life quality interviews, and shadowing of sessions. They are also available to consult on challenging cases.
- Exit interview that includes collaborative discussions with the mental health center staff in identifying strengths and challenges of service provision, and where improvements or changes can be made. This time has been extremely beneficial to both mental health providers and the Division of Mental Health, as it has allowed us to further partner together in transforming the mental health system.

Integrated Treatment

In fall 2007, the State of South Dakota was awarded a COSIG grant through SAMHSA, providing a major boost to implementation of integrated services for individuals with co-occurring mental health and substance use disorders. The Division of Mental Health (DMH), the Division of Alcohol and Drug Abuse (DADA), and the Human Services Center (HSC) have collaborated with providers in the development of a statewide quality improvement process in engaging programs in being co-occurring disorder capable programs. This grant is providing resources at the state and agency levels to support implementation of the Comprehensive, Continuous, Integrated System of Care (CCISC) Model, which is the backbone of a core infrastructure for integrated treatment. The state has hired a project coordinator, for the COSIG grant, who is collaborating with stakeholders on grant evaluation, expansion of resources for consultation, training and technical assistance. The Directors of the DMH and the DADA, the Executive Director of the Council of Mental Health Centers, and the Administrator of HSC have begun regular meetings of a "leadership team" to organize key elements of grant activities associated with implementation of integrated treatment. In addition, DMH and DADA staff have attended joint meetings with Drs. Minkoff and Cline (consultants to the project) to conduct local provider technical assistance visits. Change Agents within community mental health centers and alcohol and drug providers have been identified and are receiving training on Integrated Longitudinal Strength-Based Assessments (ILSA), treatment planning, screening and identification of individuals with co-occurring

disorders, and how to build integrated care into the system. Strength-based, comprehensive assessments will aide providers in developing individualized plans of care for individuals with mental illness and co-occurring disorders. Upcoming trainings over the next year will include a workshop on SAMHSA's Tip 42: Substance Abuse Treatment for Persons with Co-Occurring Disorders; additional lecture and demonstration on development of ILSA; and, formulation of treatment planning for individuals with co-occurring disorders. In addition, the Division of Mental Health has now revised the contracted service agreements with community mental health centers to include recovery focused, co-occurring language. See Table C-Description of Transformation Activities for more information.

Suicide Prevention and Intervention

The Division of Mental Health is represented on the Statewide Suicide Prevention Workgroup, which created a statewide suicide prevention and intervention plan. The South Dakota Strategy for Suicide Prevention Plan was presented to the Legislature during the 2005 Legislative Session. The South Dakota Strategy for Suicide Prevention website (http://www.sdsuicideprevention.org) was launched in June 2006. Access to suicide prevention/intervention skills training and toolkits for communities and schools are now readily accessible through the internet. Since 2006, there has been a rejuvenation of the Statewide Suicide Prevention Workgroup, which has included a major emphasis on supporting local task forces to develop community suicide prevention and intervention activities and link them to one another to build a statewide network of support and resources.

The DMH was fortunate in securing a three-year, SAMHSA- State/Tribal Youth Suicide Prevention and Early Intervention Grant. This grant was written based on the South Dakota Strategy for Suicide Prevention, which provides a public health approach to suicide prevention and intervention. This poses an opportunity to impact the State's high rate of suicide by targeting 14-24 year olds through high school and university education, training, and awareness activities. Grant activities include providing training on Suicide Prevention Skills, implementing curriculum in high school classes focused on building suicide prevention skills in youth, and collaborating with local suicide task forces to build local/regional networks of support to improve the early intervention, referral, and follow-up process.

Data Infrastructure and Performance Indicators

The DMH and the Division of Alcohol and Drug Abuse collaborated on the development of a more comprehensive management information system (MIS). Both Divisions share the State Treatment Activity Reporting System (STARS). With STARS, both divisions can collect the data necessary to measure outcomes in the community-based systems, as well as meet HIPAA and federal reporting requirements. All eleven community mental health centers provide demographic and service utilization to the Division through STARS. The Division also has increased reporting capabilities for the CMHS Block Grant indicators, the URS Tables, as well as state specific performance indicators. Currently activities around data infrastructure are focused on development of performance indicators captured at point-in-time intervals that focus on identification of

service outcomes that are consumer driven and recovery-oriented. Once performance indicators are identified, the Division of Mental Health will build the infrastructure into STARS to capture this data.

Evidence-Based Practices

Over the last two years, the DMH worked with the four Assertive Community Treatment (ACT) programs within the state to ensure programs are meeting fidelity to the ACT model. Included in this process was the development of performance measures and outcomes that are recovery-oriented in nature, specifically around employment, living situation, and criminal justice involvement. The ACT Programs and the Division of Mental Health have implemented Quality of Life Self Assessments that are completed by consumers on a six-month basis. These forms collect information on the individuals' sense of well-being; how they are doing (functional status); and what they have (access to resources and opportunities). This information is shared with the treatment team to help consumers and clinicians develop treatment plans. In addition, ACT program staff must also complete a quarterly report form on each consumer that collects data on employment status, hospitalizations, living arrangement, education, and substance abuse/gambling issues. Both the Quality of Life Self Assessments and the Quarterly Reports are entered into STARS, with the capability of both local programs and the State being able to run reports looking at outcomes of services.

The Clinical Management Team is currently reviewing the Illness Management and Recovery and the Family Psychoeducation Toolkits to determine capability of implementation in the near future.

Providers and Consumer Involvement

In 2007, The DMH consulted with the Depression and Bipolar Support Alliance (DBSA), in conjunction with NASMHPD's National Technical Assistance Center, and with support from SAMHSA's Center for Mental Health Services to sponsor a Transformation, Recovery, and Peer-Support Institute (TRPSI). This consumer-run institute will took place in fall of 2007 as part of the annual South Dakota NAMI conference. South Dakota consumers, family members, and community mental health providers gathered to build plans together to make recovery real in South Dakota. Current and future plans include partnership with the National Empowerment Center (NEC) to provide training to providers on their role in supporting individuals with mental health issues on their road to recovery.

During early 2008, consumers organized a grass roots effort to develop a statewide consumer advocacy organization, and brought in the National Empowerment Center to provide a "Finding Your Own Voice" technical assistance workshop to consumers. The Division of Mental Health was able to provide stipends to 45 consumers from across the state to attend the workshop. These consumers have developed a strong beginning for consumer advocacy within the State of South Dakota. Consumers came away from the training with a united voice, a name for the organization (South Dakota United for Hope and Recovery (SDUnited)), and a vision statement for SDUnited. They also formed a

planning committee, whose members are now working on the steps needed to create a formal statewide consumer advocacy organization.

Correctional Release Planners

During FY08, Release Planners in the correctional facilities continue to meet with various community agencies including community mental health centers and alcohol drug providers to coordinate discharge planning and development of appropriate release plans for inmates with mental illnesses paroling from correctional facilities. This coordinated effort is assisting parolees to receive the services they need and to reintegrate into society with the most successful outcome possible.

South Dakota

Adult - State's Vision for the Future

Adult - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

State's Vision for the Future

The Department of Human Services (DHS) vision is "CHOICES." CHOICES stands for Community, Hope, Opportunity, Independence, Careers, Empowerment, and Success.

The Division of Mental Health mission statement reads, "To ensure children and adults with mental health disorders in our communities have the opportunity to choose and receive effective services needed to promote resiliency and recovery."

While the State's community based mental health system has improved, there are still considerable challenges. The Division of Mental Health will not be satisfied upon gaining aptitude in transformational activities, but rather strives to maintain an ongoing, continuous, quality improvement mentality.

Currently, transformation of the community mental health system for adults with severe and persistent mental illness involves development of recovery-oriented services that are strength-based and consumer-driven, including integrated treatment for individuals with co-occurring disorders.

The Division recognizes that responsiveness to individual needs/wants and cultural differences must be integrated into all transformation activities. In addition, transformation needs to include state agencies, providers, clinicians, consumers, and families.

The Division also recognizes that this transformation process has several common features across all the initiatives that reflect a unifying theme:

- Services that are welcoming, are consumer driven, and are person and family centered
- Services that are hopeful, empathic, culturally appropriate, integrated, continuous, and recovery oriented
- System change efforts that involve a partnership in quality improvement that welcomes, includes, and empowers all levels of the system, including consumers, families and other stakeholders, in the continuous quality improvement (CQI) change process

Recovery

The Division of Mental Health, the Advisory Council, and community mental health centers recognize the importance of consumer-driven, strength-based, recovery-oriented treatment that addresses the co-occurring needs of individuals. As providers improve their individual and family assessment tools, consumers are empowered by identifying strengths. In addition, improved assessments help in identifying co-occurring needs. Development of individualized plans of care for adults with serious mental illness includes strengths identified through the assessment process. This also allows consumers active participation in their own treatment and recovery. The involvement of consumers and families in the move to orient the system towards recovery remains crucial, and the

Division of Mental Health will continue to work to involve and support consumers in this system transformation.

During FY09-11, the Division of Mental Health and the CMT will continue to evaluate the accreditation process and make changes as needed. The accreditation process will remain a strength-based, technical assistance process promoting recovery, but with more of a focus on identification and addressing of individual's co-occurring needs. Additional changes that will be discussed over the next three years include the addition of consumers and/or family members to the accreditation review teams.

Plans also include increasing consumer/family member involvement in provider trainings on recovery and development of meaningful outcomes. The emphasis of these trainings will be encouraged during the accreditation process mentioned above and will involve technical assistance on the recovery and co-occurring needs that consumers/family members may have addressed in training. The feedback gathered from consumers during the assessment, development and implementation of transformational activities is critical to the success and progress throughout the system.

Furthermore, the Division of Mental Health is promoting recovery and co-occurring services through modifications to administrative rules, implementing recovery focused, co-occurring language in service agreements and working to create a financial system that supports individual, consumer-driven services, while addressing the unique local needs of providers and consumers.

To support South Dakota as it transforms its mental health system to be more recovery/resiliency-oriented, person-centered, and driven by consumers and family members, the Depression and Bipolar Support Alliance (DBSA), in conjunction with NASMHPD's National Technical Assistance Center, and with support from SAMHSA's Center For Mental Health Services, sponsored the 2007 Transformation, Recovery, and Peer-Support Institute (TRPSI). This consumer-run institute took place in fall of 2007 as part of the annual South Dakota NAMI conference. South Dakota consumers, family members, and community mental health providers gathered to learn from each other's unique perspectives, and build plans together to make recovery real in South Dakota. Plenary sessions and workshops included topics such as:

- Building partnerships to cooperatively transform Mental Healthcare in South Dakota
- How Self-Help / Peer Support can be used to support the traditional mental health system
- Advocacy Thru Self-Help / Peer Support
- Growing Your Grassroots Organization
- The Emerging Movement of Consumers as Providers
- Planning for Transformation in South Dakota
- Beyond Stabilization: Recovery-Orientation for Providers
- Creating a Statewide Recovery Network

During early 2008, the Division of Mental Health supported the grass roots efforts in the development of a statewide consumer advocacy organization. Forty-five consumers attended a day and a half training sponsored by the National Empowerment Center. Consumers came away from the training with a united voice, a name for the organization (SDUnited), and a vision statement. They have also formed a planning committee, focused on the steps needed to create a formal statewide consumer organization. The Division of Mental Health will continue to encourage and support consumers in this endeavor. The Division of Mental Health plans to continue collaborating with consumers to bring the National Empowerment Center back to our state for provider and consumer training in supporting individuals with mental health issues on their road to recovery.

Integrated Treatment for individuals with mental health and substance use issues
Individuals and families with co-occurring psychiatric and substance disorders and disabilities (CODD) in South Dakota are recognized as a population with poorer outcomes and higher costs in multiple clinical domains. In March 2006, the Department of Human Services convened key stakeholders including consumers, providers, higher education, advocacy groups, tribal representatives, state government officials and other interested parties that have agreed to adopt the Comprehensive, Continuous, Integrated System of Care (CCISC) model for designing statewide systems change to improve access and outcomes for individuals with CODD.

The Department of Human Services, including the Division of Mental Health (DMH), the Division of Alcohol and Drug Abuse (DADA), and the Human Services Center (HSC) (state inpatient psychiatric facility) considers this co-occurring initiative as one of its highest priorities. Drs. Minkoff and Cline are providing consultation to the state as part of this initiative. During the past year, the CCISC implementation process has made slow progress, with gradual involvement of additional mental health and addiction providers throughout the state. The initiative received a major boost when South Dakota was awarded the COSIG grant in fall 2007. The state has now hired a Grant Coordinator, who has implemented steps to start project evaluation and exploration of expansion of resources for consultation, training and technical assistance. A statewide Change Agent group is now in place. All community mental health centers and substance abuse providers have assigned change agents within their local programs. The statewide group reflects a wide diversity of clinicians from many backgrounds and services, including Native American services, and prevention services. A curriculum manual has been developed for the Change Agents, accompanied by trainings on how to implement welcoming policies and procedures, screening and counting of individuals with co-occurring disorders, and integrated, longitudinal strength-based assessments. Plans include creation of workgroups that will include the DMH, the DADA, HSC administration, and Change Agent representation. These workgroups will explore such issues as billing/reimbursement for services and scope of practices/core competencies for clinicians to provide integrated treatment. Every community mental health center and alcohol/drug provider are in the process of developing Action Plans for implementation of integrated treatment, as well as participating in on-site agency reviews with Drs. Minkoff and Cline. Technical assistance and on-site training will continue throughout all

three years of the Block Grant. See Adult Plan, Table C: Description of Transformation Activities for more information on this initiative.

Workforce Development

Workforce issues are a complex blend of training, professional, organizational, and regulatory issues across the state of South Dakota. The Division of Mental Health works closely with the community mental health centers and the Advisory Council to improve workforce recruitment, retention, diversity, and skills training. Some of the areas in workforce development that are currently being addressed or have plans in the future include:

- Teaching of evidence based approaches to practice-South Dakota is using the SAMHSA Toolkits for Assertive Community Treatment, Illness Management and Recovery, and Family Psychoeducation
- Effective teaching methods and strategies-A curriculum manual and ongoing consultation and training with Drs. Minkoff and Cline are preparing clinicians to provide welcoming, recovery-oriented, strength-based services in an integrated system of care. These trainings/consultations will be ongoing over the next three years of the grant.
- Curriculum that incorporates competencies essential to practice-the CMT is currently focusing on the development of core competencies for providing integrated, recovery-oriented, and consumer driven mental health services.
- Build skills in treating people with co-occurring mental health and substance use issues-Implementation of the CCISC model, trainings in strength-based assessments and treating the "whole" person. This also includes consultations/trainings with Drs. Minkoff and Cline over the next three years.
- Continued focus on development/training to provide culturally aware and competent services

Focus and Expansion in Other Areas

As part of the continued quality improvement process in development of recovery-oriented services and integrated treatment for individuals with co-occurring disorders, the Clinical Management Team (CMT), which includes representation from the Division of Mental Health, community mental health centers, and consumers focus on the recovery vision statement developed by the CMT in 2006. This vision statement reads, "Recovery is an individualized process of being connected to others, satisfied with life and hopeful for the future." The CMT continues to work on the development of performance measures around outcomes of services, specifically point in time indicators on employment, living situation, and criminal justice involvement. As part of performance indicator development, the CMT is involved in creation of forms to capture the data. Once completed, this information will be included in the state management information system, thereby adding the capability to improve data driven planning. In addition, the CMT is currently reviewing the Illness Management and Recovery and the Family Psychoeducation Toolkits to develop plans for future implementation of additional evidence based practices across the state. The Division of Mental Health realizes this

change involves long-term development plans and will be working on goals and objectives in this area over the next three years of the grant and beyond.

Along with services that are culturally competent and responsive, the Division of Mental Health and the Advisory Council understand the importance of implementing ones that are also evidence-based. The Division of Mental Health, with assistance from the Data Infrastructure Grant (DIG) funding, worked with four Assertive Community Treatment programs, known as IMPACT (Individualized, Mobile, Programs of Assertive Community Treatment) within the state. Together, we are increasing evidence based practice training and evaluation. The Division implemented reporting requirements on quarterly report forms as well as quality of life surveys for each individual receiving IMPACT services, which is then reported in STARS (the state MIS system). This allows one repository to report important performance indicators associated with assertive community treatment. As this data is collected and analyzed, the processes for collecting/reporting will continue to be refined.

The South Dakota Governor's Healthcare Commission was created by the 2003 legislature and charged with gathering data to assess the health status of South Dakotans, identifying health care priorities that address financing, delivery and programming, and developing measurable health outcomes for selected state initiatives for health care. The legislature also directed the commission to recommend health care policy, monitor health care environments, and address the health care needs of South Dakotans. Representation on the commission includes business and employers, consumers, insurers, health care providers, public and community health workers, Governor's office staff, former legislators, tribal members, mental health providers, and the Indian Health Service. Mental health has been identified as a key area and the Division is playing an active role in the Mental Illness and Depression Subcommittee that has been formed.

Recently, the Governor's Healthcare Commission identified improving the ability of primary care providers to meet the needs of their patients with mental health care needs as a high priority. As a result, the Division of Mental Health applied for and received a Wellmark Foundation Grant to address treating of depression by primary care physicians. Grant activities sought to demonstrate improved depression care in primary care settings through a pilot project with nine community health clinics in central and south central South Dakota. This is a collaborative effort between the Health Care Commission's Sub-Committee on Mental Illness and Depression, the Division of Mental Health, the South Dakota Council for Mental Health Centers, and the WICHE Mental Health Program. The Division of Mental Health is now analyzing the results from the grant and is exploring options that may allow us to expand these types of screenings across the state.

South Dakota

Child - Service System's Strengths and Weaknesses

Child - A discussion of the strengths and weaknesses of the service system.

Strength and Weaknesses of the Service System

As the Division of Mental Health (DMH) and the Planning and Coordination Advisory Council holds discussions on plans/goals for the community mental health system, focus for transformation is on changing the philosophy driving services to be built around a system of care and integrated for children and families with co-occurring disorders. The President's New Freedom Commission on Mental Health's final report drove the process of planning for ways to improve the system of care for individuals with mental illness. As part of the discussion, we focused on strengths and weaknesses of the system that fall in line with the goals and recommendations of the New Freedom Commissions final report.

Goal 1: Americans Understand that Mental Health is essential to Overall Health

Strengths

Suicide Awareness Project

The DMH was fortunate in securing a three year, SAMHSA- State/Tribal Youth Suicide Prevention and Early Intervention Grant. This grant was written based on the South Dakota Strategy for Suicide Prevention, which provides a public health approach to suicide prevention and intervention. This poses an opportunity to impact the State's high rate of suicide by targeting 14-24 year olds through high school and university education, training, and awareness activities. Grant activities include providing training on Suicide Prevention Skills, implementing curriculum in high school classes focused on building suicide prevention skills in youth, and collaborating with local suicide task forces to build local/regional networks of support to improve the early intervention, referral, and follow-up process.

Indigent Medication Program

The DMH has worked to develop a seamless system so that children and families are not left without medications because of funding restrictions. More information on the Indigent Medication Program can be found in Adult Plan, Criterion One, Available Services.

Staffing and Resources

Community based mental health administration within the Division of Mental Health is accomplished with only eight staff members. Even with the relatively small staff, the Division of Mental Health has been successful in securing competitive grants to assist in transformation of the community based mental health system. Such grants include the Primary Care Grant, the State/Tribal Youth Suicide Prevention and Intervention Grant, and the Data Infrastructure Grant.

Continuous Quality Improvement

The Division of Mental Health, the community mental health centers, and the Advisory Council all recognize and include the development of ongoing quality improvement (QI) efforts that continues throughout implementation of transformational activities and beyond. The focus of transformation activities over the last year has been on increasing the consumer/family voice in planning and policy decision-making. In addition,

community mental health centers are beginning to develop "welcoming policies" that promote recovery, consumer/family driven treatment, and integrated treatment for individuals with co-occurring disorders throughout the community mental health system.

Weaknesses

Funding

Lack of additional funding and current funding restrictions make it difficult to support the implementation of a system of care model that includes integrated treatment for youth with co-occurring disorders and their families. This has slowed the transformational process in our state. In addition, much of the State's funding for transformation activities remains fragmented, as each State agency (Department of Corrections, Unified Judicial System, Department of Education, Department of Social Services, and the Division of Alcohol and Drug Abuse) within their own budget structure without flexible or blended funding options for transformation activities and services.

Stigma

Stigma remains an issue in the delivery of mental health services across the state. The loss of anonymity when seeking services combined with the tendency to stereotype mental health services creates a barrier for those who are in need of such services. This is especially true in rural areas where fewer service and support options exist. Although accessibility in a rural state will always be an issue, the Division of Mental Health is working closely with the Advisory Council and community mental health centers to battle the stigma of mental illness and receiving mental health services.

Goal 2: Mental Health Care is Consumer and Family Driven

Strengths

Individualized, Person-Centered, Family Driven Planning

The DMH consulted with the Depression and Bipolar Support Alliance (DBSA), in conjunction with the National Association of State Mental Health Program Directors (NASMHPD) National Technical Assistance Center, and with Support from SAMHSA's Center for Mental health Services to sponsor a Transformation, Recovery, and Peer-Support Institute (TRPSI). This consumer-run institute took place in Fall of 2007 as part of the annual South Dakota NAMI conference. South Dakota consumers, family members, and community mental health providers were given the opportunity to come together to build plans to make recovery real in South Dakota.

The Clinical Management Team (CMT) Sub-Group for Children has worked extensively on developing Systems of Care (SoC) for children and families receiving mental health services in South Dakota. SoC principles have been adopted by all eleven community mental health centers. The principles of a system of care include:

1. The system of care should be child-centered and family focused, with the needs of the child and family dictating the types and mix of services provided.

2. The system of care should be community-based with the locus of services as well as management and decision-making responsibility resting at the community level.
3. The system of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.

Included in activities is a Systems of Care Pilot Project at Behavior Management Systems in Rapid City. This Pilot Project is targeting youth who meet Intensive Case Management eligibility criteria and their families. See Children Plan, Criterion 1, Available Services for eligibility criteria on Intensive Case Management. Objectives of the Pilot include local planning with all child serving agencies and infrastructure development, trainings on essential components of a systems of care framework, and evaluation of the system of care and sustainability. This Pilot Project is currently in the beginning stages of implementation. Activities will continue over the next few years, with plans to provide the opportunity for all community mental health centers to participate in training and evaluation activities.

The DMH and the Mental Health Planning and Coordination Advisory Council collaborate to identify system needs and set future priorities for the community based mental health system. The Mental Health Advisory Council provides valuable input into the development of goals and objectives related to the transformation efforts around the initiatives for integrated treatment and implementation of systems of care for children and families. They bring a unique perspective to discussions as they share personal experiences about the positives and negatives they have encountered on their journey. The consumer and family members on the council also advocate for their peers, sharing the stories and concerns of other consumers and families so that the system might improve and appropriate goals are addressed. The DMH and the Advisory Council have developed a very close working relationship, recognizing the importance of all stakeholder involvement in strategic planning processes. The Advisory Council is very involved in the development of all goals and objectives for the CMHS Block Grant and provides ongoing feedback to the Division of Mental Health regarding issues related to service delivery within the community-based mental health system. During the last year, Advisory Council members have participated in a training workshop provided by the National Association of Mental Health Planning and Advisory Councils. This workshop provided valuable information to Planning Council members on the Block Grant, the importance of monitoring community mental health services, and how to improve advocacy efforts across the state for individuals with mental illness.

Consumer/Family Involvement in Planning, Evaluation and Services

Representation on the Planning and Advisory Council, Consumer Council and Clinical Management Team, gives consumers and family members the opportunity to share their ideas on development, implementation and evaluation of the transformation activities invested in by stakeholders. In Section II- States Vision for the Future it is clear that consumer and family involvement will be ongoing with plans for expansion on future projects.

Community Based Services
Intensive case management services are provided at nine of the eleven community mental health centers, with plans to add the services to the final two community mental health centers in SFY10. The target population for intensive case management is any child age 18 and under, or between the ages of 18-21 who is considered to be at-risk of out of home placement and in need of intensive services. Child Plan, Criterion One: Available Services for more detailed information on Intensive case management services.

Employment
The State Vocational Rehabilitation Agencies, Division of Rehabilitation Services and Services to Blind and Visually Impaired fund the Project Skills Program. This provides an opportunity for students with disabilities to gain paid employment while in high school. Project Skills is a cooperative arrangement between the State VR agencies and the local school systems to provide the job development, job coaching and follow-along for the student at the job site. This allows students with disabilities to take advantage of an important learning, maturing and socializing experience. See Child Plan, Section III, Criterion One, Available Services for more information regarding Project Skills.

Seclusion and Restraints
Over the past five years, the Human Services Center has been very successful in reducing the number of seclusion and restraints used within the hospital. This has been accomplished through continuous trainings on non-violent crisis intervention for all direct patient staff at the Human Services Center.

Correctional Facilities
The Division of Mental Health in cooperation with the Division of Alcohol and Drug Abuse and the Department of Juvenile Corrections conduct joint intake screenings and assessments with youth entering State Treatment and Rehabilitation (STAR) Academy, a DOC facility for juveniles. This process allows better identification of youth with co-occurring mental health and substance use issues upon their arrival on campus. Once identified, the goal is to provide specific services to the youth in a manner that best addresses the co-occurring issues. In addition to the intake process, the Division of Mental Health and the Division of Alcohol and Drug Abuse have developed a joint transition/discharge process that will set youth up with services in their home community prior to discharge from STAR Academy.

Weaknesses
Lack of Affordable Housing
Overall, there is a shortage of affordable housing opportunities for families within the state. For individuals that have criminal backgrounds and are in need of mental health services, many of the housing options become even more limited.

Youth Consumer Support
The combination of poverty and remoteness facing rural areas presents challenges in offering a full array of services such as youth-run/peer support groups.

Family-based Advocacy Organization
South Dakota has limited choices of options for families to seek out support and learn important advocacy skills while receiving services through the community mental health system. Families need an opportunity to come together with one voice to provide the family perspective on needs and priorities for improving the community mental health system.

Goal 3: Disparities in Mental Health Care are Eliminated

Strengths
Rural Mental Health Care Access
Many community mental health centers have established satellite offices in smaller communities to improve access to services. In addition, creative funding has improved access to mental health care in rural areas through development of a rural rate and Medicaid reimbursement for tele-pyschiatry services. The rural rate helps to support the State's vision of providing services in the home community or most appropriate setting.

Weaknesses
Cultural Competency
Disparities in culturally competent mental health services exist. The Division of Mental Health works to integrate cultural awareness and competency into all transformation activities. The Division of Mental Health works closely with the Advisory Council and community mental health centers to identify cultural competence needs so that individuals receiving mental health services can be served appropriately based on their unique needs.

Rural Needs
Rural areas also suffer from a shortage of mental health providers, particularly psychiatrists. Rural areas have difficulty recruiting and retaining these professionals as low salaries and rural living often are not attractive when compared to other competitive market areas.

Goal 4: Early Mental Health Screening, Assessment and Referral to Services is Common Practice

Strengths
Early Identification and Referral Efforts
The State/Tribal Youth Suicide Prevention and Intervention Grant is providing support for teachers in twenty five high schools and counselors/resident assistants at two South Dakota universities on early identification and referral processes for youth at risk of suicide. Activities include the Applied Suicide Intervention Skills Training (ASIST) which enhances early identification skills necessary to ensure proper referrals are made for youth at risk of suicide; training and follow up for school counselors on referral to mental health services for individuals at-risk, and implementation of the LifeLines curriculum in the core curriculum classes for eighth and ninth graders in the twenty five

high schools. Additional information on the Suicide Grant can be found in Table C: Description of Transformation Activities.

The Division of Mental Health maintains a partnership with the Department of Health to continue the social/emotional screenings occurring within the community health system. These screenings have improved the outreach to lower income families that are in need of mental health services. Community health nurses conduct the screenings and refer families for services during routine checkups.

The Division of Mental Health collaborates with the Office of Child Care to promote early childhood consults for daycare providers. Community mental health center staff are available to daycare providers across the state to offer technical assistance for those providing care for children with emotional and/or behavioral issues.

As part of a public/private partnership, the Division of Mental Health collaborates with the Children's Mental Health Awareness Workgroup to focus on education of mental illness, battling stigma, and early identification and referral of children/families in need of mental health services. They recently published a Parent's Guild to Children's Mental Health Services (http://sdvoicesforchildren.org/images/pdf/ParentsGuide.pdf).

Integrating CODD Services

Stakeholders across the state have come together through a co-occurring initiative to adopt the Comprehensive, Continuous, Integrated System of Care (CCISC) model. Through a SAMHSA Grant for Treatment of Persons with Co-Occurring Disorders, the Division of Mental Health works closely with the Division of Alcohol and Drug Abuse to integrate services for individuals with co-occurring mental health and substance abuse issues. All stakeholders involved have agreed on the importance of building a system for co-occurring disorders and have committed resources to help improve services to individuals with co-occurring disorders. Every community mental health center and alcohol/drug provider across the state has received on-site technical assistance (TA) on the Co-morbid Program Audit Self Survey (COMPASS) to assess program competencies and assist in the implementation of the CCISC model. Mental Health and Alcohol and Drug Providers are now developing action plans to implement integrated treatment throughout the service systems. In addition, community mental health centers and alcohol and drug providers are developing screening tools and being encouraged to implement. See Table C: Description of Transformation Activities for more detailed information on the CCISC model.

Weaknesses

Stigma

Stigma in South Dakota creates a challenge in early detection of mental health disorders through screening and assessments as individuals are reluctant to seek mental health services and often go undetected in primary care settings.

Goal 5: Excellent Mental Health Care is Delivered and Research is Accelerated

Strengths

State Agency Collaboration

A Children's System of Care Steering Committee was created to begin to address the needs of children/youth and their families receiving services from many different agencies. Representation on this Committee includes the Departments of Human Services, Social Services, Corrections, and Education, as well as the Unified Judicial System. Despite no additional funding for systems of care development, the SOC Steering Committee is attempting to move forward with in creating a seamless service delivery system for children with SED and their families.

In June 2007, the System of Care Pilot Project hosted a Search Conference in Rapid City, South Dakota. The Search Conference, entitled, *Expanding Partnerships: The Future of Integrated Services for Children and Families*, was held in Rapid City with the goal of developing a specific action plan and exploring necessary components of an effective system of care, including how it will function and steps to achievement. Professionals from different agencies and disciplines, families of consumers, and community members participated in conference activities. See Table C: Description of Transformation Activities for more information on the Search Conference and Systems of Care development.

Weaknesses

Workforce

As South Dakota moves forward with systems transformation more workforce training is needed to ensure the full opportunity of recovery and resiliency for individuals with mental illness. Lack of additional funding and continued decreases in Block Grant funding make it more difficult to address workforce issues. Many community mental health centers have presented joint trainings and utilize inter-agency technical assistance, but without formal funding and infrastructure, the process is slow. There is also a shortage of qualified professionals to work in the community mental health centers. Individuals entering the community based mental health system directly from higher education often times do not have the training to provide community-based, system of care oriented services to children/youth with serious emotional disorders and their families, and many have not been introduced to the co-occurring, integrated treatment model or working within a child and family team. Further, psychiatry services in the rural and frontier areas of the state pose a significant challenge to providing a broad continuum of care. Often psychiatrists are not willing to live and work in these rural and frontier areas, and contracting with those who are willing is very expensive for mental health providers. Overall, competing agencies and private practice create a climate where competitive salaries are an issue. Combine this with the rural layout of the State and recruitment and retention become hard issues to deal with in some areas of the state. Limited funding makes it difficult to provide youth, consumer, and family support within the current service delivery system. Resources are needed to build peer and family to family supports.

Goal 6: Technology is used to Access Mental Health Care and Information

Strengths

Management Information System

The Division of Mental Health and the Division of Alcohol and Drug Abuse utilize a comprehensive, shared, management information system. The State Treatment and Reporting System (STARS) allows the Division of Mental Health to collect performance indicators on the national outcome measures. In addition, the Division has been working with the Clinical Management Team to review outcome measures and refine the performance indicators collected in STARS. Performance indicators include point-in-time measurements of criminal justice involvement, living arrangement, and employment status. Also included in this discussion is the implementation of evidence-based practices and performance indicators related to these practices.

Weakness

Expansion of Tele-psychiatry Services

The DMH has implemented Tele-psychiatry Service as stated above in Goal 3 strengths. However, as many rural communities lack the equipment or resources to purchase the equipment necessary to implement this useful tool, expanding this program has been difficult.

South Dakota

Child - Unmet Service Needs

Child - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

Unmet Needs

The Division of Mental Health, the Mental Health Advisory Council, and the community mental health centers have worked together to recognize unmet needs and service gaps across the community mental health system. Below are brief descriptions organized by area of need.

Training and Family Advocacy

Lack of additional funding and continued decreases in Block Grant funding make it difficult to provide children, families, and providers the necessary technical assistance and training opportunities on systems of care. Ensuring System of Care principles and values are shared across all stakeholder groups/disciplines is very important in the transformation of the community mental health system. In addition, youth transitioning to the adult mental health system need supports that will assist them in a successful transition in the community.

Although community mental health centers have endorsed implementation of the Comprehensive, Continuous, Integrated System of Care (CCISC) Model of integrated treatment for individuals with co-occurring disorders, there remains a need for additional training and technical assistance on implementation of integrated services for individuals receiving community mental health centers. These trainings include development of action plans for implementation, creation of screening and assessment tools, conducting integrated strength-based assessments, and development of policies and procedures on welcoming, integrated services for individuals with co-occurring disorders.

Additionally, there is a gap between higher education and the community mental health system. Professionals entering the community-based mental health system have not received training on strength-based, family-driven, integrated systems of care to children with serious emotional disorders and their families. The Division of Mental Health needs to continue collaborative efforts with higher education institutions to include important transformation activities in curriculums taught in colleges and universities.

South Dakota does not currently have funding to support ongoing consumer and family advocacy efforts that focus on issues related to mental health services provided to children with serious emotional disorders and their families. The Division is in support of children and families developing an advocacy organization so they might collaborate and assist in transforming the community mental health system into a system that is responsive to and driven by children and families receiving services.

Evidence-Based Practices, Data Collection, and Research

The majority of South Dakota is rural/frontier, with scarce resources, isolation, and transportation difficulties posing challenges with the implementation of evidence-based practices consistently across the state. Despite these barriers, the Division of Mental Health, the Advisory Council, and community mental health centers recognize the importance of further researching evidence-based practices that may fit with system of care development. Furthermore, the Division of Mental Health and the community mental health system do not currently have data infrastructure in place to conduct point-in-time measurements for important performance indicators relative to systems of care. These indicators include such measurements as change in living situation, criminal justice involvement, out-of-home placements, improved functioning,

and social connectedness. Continued focus needs to be on ensuring children and families are full participants in the development and implementation of performance indicators and a continuous quality improvement process relative to measuring the quality of mental health services and whether they reflect mental health services that are resiliency-based, family driven, and provided in an integrated system of care.

Access to Services and Workforce Development

Access to services throughout South Dakota remains an important issue, but especially in the very rural/frontier areas of the state. Many of the community mental health centers have large catchment areas that encompass great distances. Mental health providers in South Dakota have difficulty recruiting and retaining an adequate number of psychiatrists and mental health care professionals in rural/frontier areas. Complicating this issue is the lack of public transportation for families without reliable transportation to reach services. Additionally, the time and cost involved in providing services to geographically remote areas contributes to workforce issues. These barriers sometimes result in children and families being placed on waiting lists, and/or having to travel long distances to receive services.

South Dakota

Child - Plans to Address Unmet Needs

Child - A statement of the State's priorities and plans to address unmet needs.

Priorities and Plans to Address Unmet Needs

The Division of Mental Health and the Mental Health Planning Council have made a major commitment to transform the delivery of services to individuals and families in the public mental health system. Transformation of the community mental health system for children with serious emotional disorders and their families includes development of systems of care for children and families and integrated treatment for children and families with co-occurring disorders. Included throughout transformation activities is the provision of services that are culturally aware and culturally competent.

As identified by the Advisory Council, the President's New Freedom Commission Goals and Recommendations that are integral to transformation activities in South Dakota are as follows:

- Goal 2: Mental Health is Consumer and Family Driven
  - 2.1 Develop an individualized plan of care for every adult with a serious mental illness
  - 2.2 Involve consumers and families fully in orienting the mental health system toward recovery
- Goal 4: Early Mental Health Screening, Assessment, and Referral to Services are common practice
  - 4.4 Screen for co-occurring mental health and substance use disorders and link with integrated treatment strategies.
- Goal 5: Excellent Mental Health Care is Delivered and Research is Accelerated
  - 5.3 Improve and expand the workforce providing evidence-based mental health services and supports.

Many of these priorities will require multiple years to implement as described throughout this Block Grant Application. The following list of priorities and plans are broken out according to the categories listed in the Unmet Needs Section.

Training

Through the System of Care Pilot Project, the Division of Mental Health will continue collaboration with the Clinical Management Team and local/regional and state offices associated with the Department of Social Services, the Department of Education, the Department of Corrections, the Unified Judicial System, and the Division of Alcohol and Drug Abuse to provide training and technical assistance on local systems of care development, core competencies of systems of care, and providing community-based services. The Division of Mental Health will continue to explore opportunities in securing additional state dollars through development of flexible funding with other stakeholders, as well as exploring opportunities for additional federal funding. In addition, community mental health centers will continue to offer college students opportunities for internships in the community-based mental health system. This affords them the opportunity to learn first hand about providing strength-based and consumer driven services in an integrated system of care.

To assist youth transitioning to adult mental health services, development of Systems of Care will assist in ensuring a continuum of care for youth and improve services and supports allowing them successful transition in their home community.

The Division of Mental Health, the Division of Alcohol and Drug Abuse, and the Human Services Center have partnered with providers in a statewide quality improvement process using the Comprehensive, Continuous, Integrated Systems of Care (CCISC) Model as a framework for engaging every program in becoming a welcoming, recovery oriented co-occurring disorder capable program, and every clinical staff person in developing welcoming, co-occurring disorder competency. Activities to date have included development of a charter document, readiness assessments of mental health and alcohol/drug providers, creation of Change Agent positions within each community mental health center and alcohol and drug provider, and preparation for implementation of action plans. This project has received a major boost when South Dakota was awarded the COSIG Grant at the beginning of FY08. The grant has provided the resources necessary at both the state and agency levels to support efforts in development of the core infrastructure for integrated treatment. Planned activities over the next three years include continued onsite technical assistance to providers, training on integrated, strength-based assessments, development of screening and assessment tools, training on SAMHSA's TIP 42, and development of billing structures and core competencies/scopes of practice on integrated treatment for children and families with co-occurring disorders. See Table C: Description of Transformation Activities for more information on implementation of the CCISC model and development of integrated treatment.

As part of the State/Tribal Youth Suicide Prevention and Intervention Grant, the Division, in partnership with Sinte Gleska University and Wakanyeja Pawicayapi, Inc., continues to offer cultural awareness training to all mental health providers, specifically on Lakota culture and beliefs. These trainings assist community mental health centers in incorporating cultural sensitivity into the services provided to consumers. Over 15 Cultural awareness trainings have taken place within the last 2 years, with an additional 15 planned during the next year. The Division of Mental Health, the Mental Health Advisory Council, and the Clinical Management Team will continue to explore training and technical assistance opportunities toward improving cultural awareness and competency across the mental health system. Furthermore, the State/Tribal Youth Suicide Prevention and Intervention Grant staff provide Applied Suicide Intervention Skills Training (ASIST) and safeTALK at no charge to providers and community members at large. These activities are furthering efforts in early identification and referral of youth at-risk for suicidal behaviors.

South Dakota families are working to establish a family run organization for the advocacy of children and youth with mental health issues, and their families. The DMH helped to partner families with such experts as Barbra Huff to provide information and technical assistance to parents/families assisting in development of an organization. Currently, the parent of a child with a serious emotional disorder is working in parallel to Barbra Huff's activities to pull families together into an organized system of advocates for community based mental health services. While the formation of this important

organization is in the early stages, its establishment, and leadership will help drive transformation in the State mental health system.

Evidence-Based Practices, Improved Data Collection, and Research

The Division of Mental Health has not implemented evidence-based practices for children with serious emotional disorders and their families. However, the Division is developing and implementing a System of Care Model across the state, including integrated treatment for children and families with co-occurring disorders. The Division of Mental Health, the Mental Health Advisory Council, and the Clinical Management Team will continue to explore opportunities for implementation of evidence-based practices for children and families that would fit into the Systems of Care Model.

Furthermore, the Division of Mental Health and the CMT are collaborating to develop the capability to provide various point-in-time measurements for important performance indicators relative to systems of care. These indicators include such measurements as change in living situation, criminal justice involvement, out-of-home placements, improved functioning, and social connectedness. In addition, as part of the SAMHSA funded Youth Suicide Prevention and Intervention Grant, development of performance indicators will also include measurements of suicide risk, early identification, and referral.

In FY05, the Division, with input from the Advisory Council and the Clinical Management Team (CMT), began implementation of an enhanced accreditation review process of the eleven community mental health centers. This process moved from a strictly documentation compliance process to one that is more strength-based and focused on individualized planning and recovery. The accreditation process provides feedback and technical assistance opportunities for community mental health centers to develop continuous quality improvement processes that move forward the implementation of recovery-oriented services for all individuals with mental illness, including those with co-occurring disorders. Plans include further development of consumer/family involvement in the accreditation process, and refinement of process to include more focus on identification and treatment for individuals with co-occurring disorders.

Access to Services and Workforce Development

The Division will continue to allow community mental health centers in the most rural/frontier areas to utilize a reimbursement rate for all services provided that is 20% higher than the regular rate for services. Tele-psychiatry reimbursement through Medicaid will also continue to play a vital role in ensuring access to services in the most rural areas.

The Division of Mental Health will continue to work with community mental health centers to provide additional trainings and technical assistance opportunities in the area of systems of care development as we work to bridge the gap between higher education and workforce readiness. As part of this effort, Division of Mental Health staff present information to University of South Dakota Social Work students. This information

includes systems of care development, core competencies of systems of care, and providing consumer and family-driven services. In addition, community mental health centers will continue to offer college students opportunities for internships in the community-based mental health system. This affords them the opportunity to learn first hand about providing strength-based and consumer driven services in an integrated system of care. The Division of Mental Health, the Advisory Council, and community mental health centers will collaborate to prioritize workforce issues and begin to assess what is needed within the state to address disparities in the services provided and the transformational activities planned.

South Dakota

Child - Recent Significant Achievements

Child - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

Recent Significant Achievements

The Division of Mental Health continues to collaborate with the Mental Health Advisory Council, community mental health centers, and consumers and families in making progress toward development of a recovery-oriented, strength-based, consumer-driven, and integrated system of care for children and families receiving services through the community-based mental health system.

Achievements listed in Section I of the Adult Plan are also included in the Children's Plan. These achievements include:

- Education/training of Advisory Council members on the Block Grant, the NAMHPAC workshop, and additional presentations from consumers, family members, and other stakeholders represented on the Council.
- Clinical Management Team and Division of Mental Health collaboration on enhancing the Accreditation Review of all eleven community mental health centers.
- Use of the CCISC model (See Table C Description of Transformation Activities for more information) for children and families with co-occurring mental health and substance use disorders.
- Suicide Prevention and Intervention Activities on both statewide and local levels through goals identified by the State Suicide Prevention and Intervention Workgroup.
- Data Infrastructure and Performance Indicator Development that includes providing information to a management information system shared by the Division of Mental Health and the Division of Alcohol and Drug Abuse.
- Provider and Consumer Involvement in trainings/workshops focused on making recovery and children/family-driven, strength-based, individualized mental health services realities in South Dakota.

Other Significant Achievements include:

Intensive Case Management

The development of Systems of Care began with an intensive case management component. The Division of Mental Health was successful in receiving funding in FY06 to support targeted staff in three community mental health centers to provide intensive case management (ICM) services to children and their families. In addition, the Division reallocated funds for FY07 to support ICM services at three additional mental centers. ICM services have shown to provide improved outcomes through fewer out-of-home placements for children/youth. In FY08, 95% of the children/youth receiving ICM services were able to remain in the home with the family. This is a very positive step in establishment of systems of care across the state. In FY09, the Division was again successful in receiving funding for an additional three community mental health centers to provide ICM Services. South Dakota now has ICM funding for nine of the eleven community mental health centers across the state. See Child Plan, Criterion One, Available Services for complete description of intensive case management services.

Systems of Care Development and the System of Care Pilot Project
The Unified Judicial System (UJS), Child Protective Services (CPS), the Department of Corrections (DOC), and community mental health center directors continue collaborative efforts to improve the referral and service delivery system for children who are referred by UJS, CPS, or DOC to a community mental health center. Memorandums of understanding (MOU) remain in place that address the referral procedures, uniform intake/referral processes, principles for co-management of referrals, and identification of service gaps.

The Division of Mental Health is collaborating with Child Protective Services (CPS) to offer mental health services targeted to families with children who are at risk of being removed from their families. The purpose of these services is to intervene early with families who are involved with CPS and prevent out-of-home placement or reunify families when this has occurred. Currently funding is available for two community mental health centers to offer this program. These programs have proven to be effective in keeping children in their homes and successfully reuniting children and families when this has occurred. The Division will continue to explore options to increase access to this service through other community mental health centers.

Integral to development of systems of care for children and families is the involvement and buy-in from all child/family serving agencies and stakeholders. A Children's System of Care (SoC) Steering Committee, which includes representation from the Departments of Human Services, Social Services, Corrections, Education, and the Unified Judicial System, continues to engage in consensus building activities in development for a shared vision and strategic plan for designing, implementing, and evaluating system of care infrastructure and services. As part of this process, the Children's SoC Committee developed and disseminated an RFP for local development of SoC. Community mental health centers applied to the SoC Steering Committee to become the SoC Project. During FY08, the SoC Pilot Project began at Behavior Management Systems in Rapid City. Western Interstate Commission for Higher Edcuation (WICHE) is providing technical assistance to the Division of Mental Health and Behavior Management Systems during this project. Over the first year of this project there has been a readiness assessment conducted, a Search Conference held, increased involvement of children, youth and families, and strategic planning sessions developing goals/objectives to assist moving towards an established system of care. All community mental health centers across the state are encouraged to send staff to trainings and conferences offered as part of this project, to start the process in as many areas of the state as possible.

Early Identification and Screening
Throughout strategic planning discussions, the Mental Health Advisory Council has continued to emphasize the importance of promoting the mental health of young children, particularly in the area of identification and intervention. Through this effort, the Division of Mental Health and the Department of Health continue to partner in providing Ages and Stages Social/Emotional Screening used in the screening process of children/families receiving services through Community Health Nurses.

The Division of Mental Health continues to work together with the South Dakota Voices for Children on increasing public awareness and understanding of children's mental health issues. In FY07, an online mental health directory and Parent's Guide to Children's Mental Health Services as developed and is now widely available across the state. (http://www.sdvoicesforchildren.org/images/pdf/ParentsGuide.pdf) Current activities include exploring additional resources for improving outcomes through investment in education and physical and mental development of children from infancy to adulthood.

The Division of Mental Health is a member of the South Dakota Alliance for Children. This is a statewide coalition of organizations, providers, professionals, and parents advocating for policies, programs, and funding that will achieve an affordable, seamless, unified, high quality childcare and early education system in South Dakota for children birth through eighth grade. One objective in the development of this unified system was to develop consultation services through community mental health centers designed to support the social emotional issues of children in childcare settings, focusing on birth to five. The Division of Mental Health collaborated with the Office of Child Care Services to utilize funding in a manner that allows mental health centers to consult with childcare providers in an effort to assist those providers in better serving children with emotional and behavioral issues. Currently, there are three community mental health centers involved in this effort.

Suicide Prevention and Intervention

The Division of Mental Health, in collaboration with the Western Interstate Commission on Higher Education (WICHE) is now in its second year of activities planned as part of the State/Tribal Youth Suicide Prevention and Intervention Grant. South Dakota's grant activities include implementation of early intervention and prevention programs in 25 high schools and 2 universities across the state. Grant activities are based on the South Dakota Strategy for Suicide Prevention, a state plan created by a public and private organization partnership. The Grant objectives are to not only reduce suicide attempts and completions in South Dakota for youths aged 14-24, but also to build awareness and improve the early identification and referral process between schools and community mental health and alcohol/drug providers for youth struggling with depression and/or suicidal thoughts.

Parent Involvement and Advocacy

South Dakota families have been working to establish a family run organization for the advocacy of children and youth with mental health issues, and their families. The DMH helped to partner families with such experts as Barbra Huff to provide information and technical assistance to parents/families assisting in development of an organization. Currently, the parent of a child with a serious emotional disorder is working parallel to Barbra Huff's activities to pull families together into an organized system of advocates for community based mental health services. While the formation of this important organization is in the early stages, they are already helping to build advocacy efforts for families involved in the System of Care Pilot Project in Rapid City. The establishment of important family involvement and advocacy, as well as leadership will help drive transformation in the State mental health system.

South Dakota

Child - State's Vision for the Future

Child - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

State's Vision for the Future

The Department of Human Services (DHS) vision is "CHOICES." CHOICES stands for Community, Hope, Opportunity, Independence, Careers, Empowerment, and Success.

The Division of Mental Health mission statement reads, "To ensure children and adults with mental health disorders in our communities have the opportunity to choose and receive effective services needed to promote resiliency and recovery."

While the State's community based mental health system has improved, there are still considerable challenges. The Division of Mental Health will not be satisfied upon gaining aptitude in transformational activities, but rather strives to maintain an ongoing, continuous, quality improvement mentality.

Currently, transformation of the community mental health system for children with serious emotional disorders involves the development of systems of care with integrated treatment for children and families with co-occurring disorders.

The Division recognizes that responsiveness to individual needs/wants and cultural differences must be integrated into all transformation activities. In addition, transformation needs to include state agencies, providers, clinicians, consumers, and families.

The Division also recognizes that this transformation process has several common features across all the initiatives that reflect a unifying theme:

- Services that are welcoming, are child/family driven, and are person and family centered
- Services that are hopeful, empathic, culturally appropriate, integrated, continuous, and recovery oriented
- System change efforts that involve a partnership in quality improvement that welcomes, includes, and empowers all levels of the system, including consumers, families and other stakeholders, in the continuous quality improvement (CQI) change process, and includes MH, CD, and DD services in all aspects of the process
- Development of regional partnerships between services and agencies to facilitate the creation of an integrated and collaborative system of care

Systems of Care

The Clinical Management Team's Children Sub-Group is committed to continued development of family-focused intervention that provides youth and families a strength-based, team-initiated multilevel change process focusing on community and family systems, and individual functioning. Efforts in this area will include development of outcome measures such as increased school participation and attendance, decrease in out of home placements, decrease in criminal justice involvement, decrease in alcohol and drug use, and most importantly, increase in child/family satisfaction with mental health

services and supports. These important indicators will assist in assessing the effectiveness of systems of care. The Division of Mental Health realizes this change involves long-term development plans and will be working on goals and objectives in this area over the next three years of the grant and beyond.

The Division of Mental Health and the Clinical Management Team also recognized that children/youth served have multiple issues and, therefore, interact with multiple service sectors. In recognizing this, a Children's System of Care Steering Committee was formed. The Steering Committee works to ensure a system of care is developed across service sectors to provide holistic services in the least restrictive settings possible. Representation includes the Departments of Human Services, Social Services, Corrections, and Education; the Unified Judicial System; and the community mental health centers. As part of this effort, the Children's System of Care Steering Committee, through an RFP (Request for Proposals) process, selected a community to become a SoC Pilot Project and serve as a train-the-trainer site for development of local systems of care. Behavior Management Systems in Rapid City was chosen as the pilot site for establishment of systems of care. Over the first year of this project there has been a readiness assessment conducted, a Search Conference held, increased involvement of children, youth and families, and strategic planning sessions developing goals/objectives to assist moving towards an established system of care. Plans for the future include continued collaboration with the System of Care Steering Committee, local/regional stakeholders, community mental health centers, and the Advisory Council to continue establishment of systems of care across the state. See Table C: Description of Transformation Activities for more detailed information on the SoC Pilot Program.

In FY08, the Division of Mental Health continued to fund intensive case management in six community mental health centers. Intensive case management is a critical component to effective systems of care. In FY09, the Division of Mental Health was successful in securing funding for three additional community mental health centers to provide intensive case management. The Division of Mental Health is committed to funding these services at all community mental health centers, and is seeking funding for the remaining two centers through the FY10 budget.

South Dakota families have been working to establish a family run organization for the advocacy of children and youth with mental health issues, and their families. The DMH helped to partner families with such experts as Barbra Huff to provide information and technical assistance to parents/families assisting in development of an organization. Currently, the parent of a child with a serious emotional disorder is working in parallel to Barbra Huff's activities to pull families together into an organized system of advocates for community based mental health services. While the formation of this important organization is in the early stages, its establishment, and leadership will help drive transformation in the State mental health system.

Integrated Treatment for individuals with mental health and substance use issues
Children and families with co-occurring psychiatric and substance disorders and disabilities in South Dakota are recognized as a population with poorer outcomes and higher costs in multiple clinical domains. In March 2006, the Department of Human Services convened key stakeholders including consumers, providers, higher education, advocacy groups, tribal representatives, state government officials and other interested parties that have agreed to adopt the Comprehensive, Continuous, Integrated System of Care (CCISC) model for designing statewide systems change to improve access and outcomes for individuals with co-occurring issues.

The Department of Human Services, including the Division of Mental Health (DMH), the Division of Alcohol and Drug Abuse (DADA), and the Human Services Center (HSC) (state inpatient psychiatric facility) considers this co-occurring initiative as one of its highest priorities. Drs. Minkoff and Cline are providing consultation to the state as part of this initiative. During the past year, the CCISC implementation process has made progress, with gradual involvement of additional mental health and addiction providers throughout the state. The initiative received a major boost when South Dakota was awarded the COSIG grant in fall 2007. The state has now hired a Grant Coordinator, who has implemented steps to start project evaluation and exploration of expansion of resources for consultation, training and technical assistance. A statewide Change Agent group is now in place. All community mental health centers and substance abuse providers have assigned change agents within their local programs. The statewide group reflects a wide diversity of clinicians from many backgrounds and services, including Native American services, and prevention services. A curriculum manual was developed for the Change Agents, accompanied by trainings on how to implement welcoming policies and procedures, screening and counting of individuals with co-occurring disorders, and integrated, longitudinal strength-based assessments. Plans include creation of workgroups that will include the DMH, the DADA, HSC administration, and Change Agent representation. These workgroups will explore such issues as billing/reimbursement for services and scope of practices/core competencies for clinicians to provide integrated treatment. Every community mental health center and alcohol/drug provider are in the process of developing Action Plans for implementation of integrated treatment, as well as participating in on-site agency reviews with Drs. Minkoff and Cline. Technical assistance and on-site training will continue throughout all three years of the Block Grant. See Table C: Description of Transformation Activities for more information on this initiative.

Workforce Development
Workforce issues are a complex blend of training, professional, organizational, and regulatory issues across the state of South Dakota. The Division of Mental Health works closely with the community mental health centers and the Advisory Council to improve workforce recruitment, retention, diversity, and skills training. Some of the areas in workforce development that are currently being addressed or have plans in the future include:

- Teaching of best-practice approaches to practice-Establishment of systems of care throughout the State of South Dakota.
- Effective teaching methods and strategies-A curriculum manual and ongoing consultation and training with Drs. Minkoff and Cline are preparing clinicians to provide welcoming, recovery-oriented, strength-based services in an integrated system of care. These trainings/consultations will be ongoing over the next three years of the grant.
- The Clinical Management Team (CMT) has developed core competencies for implementation of systems of care for children and families receiving mental health services across the state. The CMT continues to focus on these core competencies in plans for development of systems of care.
- Continued focus on development/training to provide culturally aware and competent services

Focus and Expansion in Other Areas
As providers improve their individual and family assessment tools, strengths identified during assessments are utilized in developing an individualized, family driven plan of care for every child with serious emotional disturbance and their family. This also allows children and families to actively participate in their own treatment and recovery, and become empowered through identification of strengths and supports. The involvement of children and families in the move to orient the system towards Systems of Care remains crucial, and the Division of Mental Health will continue to work to involve and support children/family members in this system transformation at all levels.

During FY09-11, the Division will continue to evaluate the accreditation process of community mental health centers, and make changes as needed. It will remain a strength-based, technical assistance model to promote recovery and systems of care, but more focus will be placed on whether co-occurring needs are being identified and addressed. Additional changes that will be discussed over the next three years include the addition of family members to the accreditation review teams, with plans to involve family members in the training of providers on systems of care and what important outcomes mean to children and families. In addition, the Division of Mental Health promotes systems of care and co-occurring services through modifications to administrative rules, implementing recovery focused, co-occurring language in service agreements and working to create a financial system that supports individual, family-driven services, while addressing the unique local needs of providers and children and families.

One tool that may assist in the State's plans for transformation is the Data Infrastructure Grant on Quality Improvement. In FY07, the Division of Mental Health submitted an application to SAMHSA for the Data Infrastructure Grant (DIG) on Quality Improvement. This grant is a third round grant that will allow the Division to build additional infrastructure between local providers and State systems to more accurately collect/report data for the CMHS Block Grant and URS Table reporting. This grant will assist the community mental health system to build the capability to report client level data, as well as collect important performance indicators relative to school participation/attendance and criminal justice involvement at various point-in-time intervals. In addition, the Division will use this grant to assist with the development of outcome driven performance indicators that will more fully involve children and family members in development and implementation of systems of care statewide.

The State/Tribal Youth Suicide Prevention and Intervention Grant is providing support in early identification and referral processes for teachers in twenty-five high schools and counselors/resident assistants at two South Dakota universities. This will be accomplished through the Applied Suicide Intervention Skills Training (ASIST), implementation of Lifelines curriculum in high schools, and training of school counselors on early identification referral processes. These activities all enhance early identification skills necessary to ensure proper referrals are made for youth at risk of suicide. Lifelines will likely be sustained in many schools to support ongoing efforts in early identification and referral processes for youth at risk of suicide.

South Dakota

Adult - Establishment of System of Care

Adult - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

Establishment of System of Care

The Division of Mental Health (DMH), in partnership with the Mental Health Planning and Coordination Advisory Council, has the responsibility to establish a system of public mental health services to meet consumers' needs. Through the purchase of service agreements with eleven non-profit community mental health centers, the Division of Mental Health provides Continuous Assistance, Rehabilitation, and Education (CARE) Program and Individualized and Mobile Program of Assertive Community Treatment (IMPACT) services to individuals identified as having a severe and persistent mental illnesses (SPMI). The agreements with community mental health centers also include the provision of outpatient services to non-targeted populations. In addition, each community mental health center receives a monthly allocation of state general funds to support emergency services throughout their catchment areas. Four community mental health centers also provide transitional housing services. Transitional housing services provide opportunities for individuals with mental illnesses to learn the skills necessary to successfully live independently.

The transformation initiative within the community mental health system for adults with severe and persistent mental illness involves strength-based, recovery-oriented services that are integrated for individuals with co-occurring disorders and disabilities. Included in this transformation of services is responsiveness to individual needs/wants as well as cultural differences. The Division recognizes that these processes need to include state agencies, providers, clinicians, consumers, and families.

The Division recognizes that these transformation processes must reflect the following themes:

- Services are welcoming, consumer driven, and person and family centered
- Services are hopeful, empathic, culturally appropriate, integrated, continuous, and recovery-oriented
- System change efforts involve a partnership in quality improvement that welcomes, includes, and empowers all levels of the system, including consumers, families and other stakeholders, in the continuous quality improvement (CQI) change process, and includes MH, CD, and DD services in all aspects of the process

During the last year, the Mental Health Advisory Council received technical assistance (TA) on increasing involvement of the Council toward improving and strengthening the community mental health system. This TA has empowered the Advisory Council to enhance their involvement in strategic planning and advocacy efforts for individuals receiving mental health services.

The Department of Human Services, which includes the Division of Mental Health, the Division of Alcohol and Drug Abuse, the Human Services Center (state inpatient psychiatric facility), and the Division of Developmental Disabilities, have identified development of integrated treatment for all individuals diagnosed with co-occurring disorders as one of its highest priorities. Drs. Minkoff and Cline are providing

consultation to the state as part of this initiative. All stakeholders involved agree on the importance of building a system for co-occurring disorders, and have committed resources to help improve services to individuals with co-occurring disorders. In addition, the state received a SAMHSA CO-SIG Grant in Fall 2007. Every community mental health center and alcohol/drug provider has received on-site technical assistance to develop integrated services for individuals with co-occurring disorders. In addition, every CMHC has completed a Co-morbid Program Audit Self Survey (COMPASS) to assess program competencies and assist in the implementation of the Comprehensive, Continuous, Integrated, System of Care (CCISC) Model. Technical assistance and on-site training on integrated treatment for co-occurring disorders is now focusing on agencies developing Action Plans to assist in implementation of integrated services throughout the community mental health system. Workgroups that include representation from Change Agents, the Division of Mental Health, and community mental health center fiscal staff and Executive Directors are working in the areas of Billing and Reimbursement Practices and Development of Core Competencies in the provision of integrated services. In addition trainings are planned that will provide technical assistance to providers in development of integrated longitudinal strength-based assessments (ILSA); provide additional information on SAMHSA Tip 42; and, development of screening and assessment tools for determining needs of individuals, including those with co-occurring disorders. These will continue over the next three years of the grant and beyond.

Furthermore, as part of implementation of the CCISC model, all community mental health centers and alcohol/drug providers have assigned Change Agents from each of their respective agencies to drive implementation of integrated services from the local levels. These individuals meet on a regular basis as a group to discuss integration of services, receive training on areas such as welcoming attitudes/policies, strength-based treatment, and screening and assessment. The Change agents are then able to take this information back to their centers to share with other staff members. The role of Change Agents in their local programs includes provision of training and supervision on the principles of the CCISC model and program consultation to facilitate development and implementation of quality improvement action planning to establish and enhance dual diagnosis capability in the programs as a whole.

See Table C: Description of Transformation Activities for more information on the CCISC model and Change Agents.

The Clinical Management Team (CMT), which includes representation from providers, consumers, and Division of Mental Health staff, continues to focus on transformation efforts designed to move the community mental health system to a more recovery focused, individualized, and integrated system of care. The CMT use the vision statement developed in 2006 as the driving force in these transformation efforts. This vision statement reads, “Recovery is an individualized process of being connected to others, satisfied with life and hopeful for the future.”

Throughout the year, the DMH and members of the Advisory Council are also participants on many task forces, workgroups, planning groups, and committees with

representatives of other stakeholder groups. Participation provides the Division of Mental Health the opportunity to take the public health approach in obtaining additional input from a larger pool of individuals and agencies when identifying important issues to consider for improvement of the community-based mental health system. Some of the workgroups that the Division of Mental Health participates with include:

- **People Leading Accessible Networks of Support (PLANS) -** PLANS is led by the Department of Human Services, Division of Developmental Disabilities. Funding is provided through a grant from the Administration on Developmental Disabilities to support people with disabilities, through a person-directed service and support philosophy of self-determination. PLANS assists each person and their chosen circle of support to develop a plan for accessing supports and services in their local community and to organize resources in ways that are life enhancing and meaningful. Representation on the workgroup includes the Division of Mental Health, the Division of Developmental Disabilities, the Division of Rehabilitation Services, the Department of Education, local providers, individuals with disabilities, and family members.
- **Freedom to Work Leadership Council-**The Freedom to Work Leadership Council was born out of the Medicaid Infrastructure Grant with the Department of Human Services, Division of Rehabilitation Services. Representation on the council includes the Division of Developmental Disabilities, the Division of Mental Health, the Department of Social Services, the Department of Labor, Division of Services to the Blind and Visually Impaired, the Social Security Administration, individuals with disabilities, and family members. The purpose of the grant is to make improvements to the Medicaid system that encourages and supports individuals with disabilities to return to work. Through the Leadership Council involvement, the State of South Dakota has further developed Personal Assistant Services (PAS) to include services being available in the workplace. In addition, South Dakota now has the Medicaid Assistance for Workers with Disabilities Program that allows working people with disabilities to pay a cost-share (such as a premium) to participate in the state's Medicaid program, just as they would if they were buying private health insurance.
- **Interagency Council on Homelessness**- The Council is challenged with a variety of duties, including identifying and defining homeless issues, determining effective strategies for the prevention of homelessness in South Dakota, providing public education, and working with various advocacy organizations, faith-based groups, and consumers regarding policy and program development. The Council consists of the Governor; Cabinet Secretaries from the Departments of Health, Human Services, Social Services, Corrections, Education, and Labor; The Adjutant General of Military and Veteran’s Affairs; The Director of Tribal Government Relations; and the Executive Director of the South Dakota Housing Development Authority.

- **Housing for the Homeless Consortium-**Involved in the Consortium are private businesses, disability service organizations, local cities/towns, public housing authorities, landlords, formerly homeless individuals, housing developers, regional community action agencies and state agencies, which includes the Division of Mental Health. The Consortium meets quarterly to provide opportunities for networking with other providers across the state, problem solve difficult situations, share ideas about "what works," share resource information, and gain knowledge of new funding opportunities. In addition, the Consortium gives South Dakota a mechanism to apply for federal homeless assistance funds from the U.S. Department of Housing and Urban Development (HUD). This includes the Continuum of Care Grant.
- **State Adult Placement Committee-**The Adult State Placement Committee formed in 2007 to assist in determining appropriate placement for individuals that have struggled with maintaining independence in the community. In addition, the Placement Committee looks at individuals aging out of the adolescent system into the adult system, especially those individuals returning from long-term placement situations, and finding the most appropriate services for these individuals to be successful living in the community. Representation on the State Placement Committee includes the Division of Mental Health, the Division of Developmental Disabilities, the Department of Social Services, the Division of Alcohol and Drug Abuse, the Department of Education, and the Department of Corrections.
- **Statewide Suicide Prevention Workgroup-**This workgroup includes representation from the Division of Mental Health, Department of Social Services, Department of Health, local providers of mental health services, the Council of Mental Health Centers, public educators, Indian Health Services, community members, and hospitals. This workgroup focuses on carrying out the goals of the South Dakota Strategy for Suicide Prevention, one of which is building a network of state coalitions/task forces. Goals and activities of the Statewide Suicide Prevention Workgroup can be found on the web at www.sdsuicideprevention.org.

South Dakota

Adult - Available Services

Adult - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing
services;
Educational services;
Substance
abuse services;
Medical and dental services;
Support services;
Services provided by local school
systems under the Individuals with Disabilities Education Act;
Case management services;
Services
for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities
leading to reduction of hospitalization.

Available Services
The Division of Mental Health, the Mental Health Planning and Coordination Advisory Council, and the community mental health centers collaborate to ensure the community based mental health system provides services that are comprehensive, culturally responsive, consumer driven, and are provided with a recovery focus to all individuals with mental health issues, including individuals with co-occurring disorders.
Although community mental health centers provide mental health services to all adults identified with mental health issues, the highest priority target group is adults with severe and persistent mental illness.

For purposes of receiving services through community mental health centers, a person with severe and persistent mental illness is defined as a person 18 or older that meets at least one of the following criteria:

- Has undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime.
- Has experienced a single episode of psychiatric hospitalization with an Axis I and/or Axis II diagnosis per the DSM-III-R or DSM-IV.
- Has been maintained with psychotropic medication for at least one year.
- Has frequent crisis contacts with a community mental health center for more than six months as a result of severe and persistent psychiatric symptomatology.

In addition to meeting at least one of the criteria above, the individual must have impaired role functioning as indicated by at least three (3) of the following:

- Is unemployed or has markedly limited job skills and/or poor work history.
- Is unable to perform basic living skills without assistance.
- Exhibits inappropriate social behavior that results in concern by the community and/or request for mental health services by the judicial/legal systems.
- Is unable to procure appropriate public support services without assistance.
- Requires public financial assistance for out of hospital maintenance.
- Lacks social support systems in a natural environment.

Community Mental Health Center Programs and Services
The eleven community mental health centers (CMHCs) that the Division of Mental Health contracts with have assigned catchment areas, broken out by county, for which they are responsible (See Attachment 3).

- All eleven CMHCs provide services through the Continuous Assistance, Rehabilitation, and Education (CARE) Program.
- Four of the eleven CMHCs operate Individualized Programs for Assertive Community Treatment (IMPACT).
- Four of the eleven CMHCs offer transitional housing services
- All eleven CMHCs are working on integrating services for individuals with co-occurring disorders into the CARE/IMPACT programs
- One CMHC includes the Serenity Hills Program, which provides integrated mental health/substance abuse treatment for individuals with co-occurring disorders.

- Seven of the eleven CMHCs are also core service agencies providing substance abuse services.

CARE and IMPACT Programs

CARE Programs

The CARE Program provides services that are comprehensive, person-centered; relationship and recovery focused, and within an integrated system of care. The CARE Program includes individually planned treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illness, including those with co-occurring conditions (substance abuse, developmental disabilities). The CARE Program is aimed at helping individuals with SPMI live successfully in the community.

Encompassed in each CARE Program is a CARE team. A CARE Team is organized as a mobile group of mental health professionals who merge clinical, medical and rehabilitation staff expertise within one service delivery team, supervised by a clinical supervisor. Services are responsive to cultural differences and special needs; incorporate mental and physical health, housing, employment, and vocation/education linkages and services, all while stressing integration in normal community settings. Outreach to consumers and provision of services according to the unique needs and potentials of each consumer are the team's highest priority, with the majority of clinical contacts occurring outside of an office setting.

Each CARE Team is responsible for maintaining an ongoing empathic, hopeful, integrated treatment relationship whether the consumer is in the community, the hospital, or involved with other agencies (i.e., substance abuse or correctional facility). The CARE team is responsible for the following services:

- Case Management, which assists individuals in gaining access to needed medical, social, educational, and other services. This includes referrals and related activities to help link the individual with providers or programs that are capable of providing needed services.
- Crisis assessment and intervention, including telephone and face to face contact available to consumers 24 hours per day, seven days per week.
- Liaison services provided to facilitate treatment planning and coordination of services between mental health centers and in-patient psychiatric hospitals, local hospitals, residential programs, correctional facilities, and in-patient alcohol/drug treatment programs.
- Symptom assessment and management, supportive counseling and psychotherapy, when diagnostically indicated, is provided to help the consumer cope with and gain mastery over symptoms and disabilities, including those related to co-occurring disorders, in the context of daily living.
- Medication prescription, administration, monitoring, and education.
- Direct assistance to ensure that the consumer obtains the basic necessities of daily life, and can perform basic daily living activities.
- Other services the CARE Team provides include:
    - Maintaining current assessments and evaluations;

- Participating in the treatment planning process;
- Monitoring consumer progress towards identified goals;
- Support in helping consumers find and maintain employment in community-based job sites;
- Budgeting and financial support, including payee services if applicable;
- Support in locating, financing and maintaining safe, clean, affordable housing
- Development of psychosocial skills and/or psychosocial rehabilitation;
- Assisting with locating legal advocacy and representation if applicable;
- Collaboration with substance abuse services, as needed.
- Encouragement of active participation of the family and or supportive social networks of an individual by providing education, supportive counseling and conflict intervention and resolution.

CARE teams are available to provide treatment, rehabilitation, and support activities seven days per week, 24 hours per day. The CARE Teams also have the capacity to provide multiple contacts per week to individuals experiencing severe symptoms and/or significant problems in daily living.

IMPACT Programs

The IMPACT Program is a comprehensive, person-centered; recovery focused, individualized and integrated system of care which provides treatment, rehabilitation, and support services to identified consumers with severe and persistent mental illness, including those with co-occurring conditions (substance abuse, developmental disabilities), and those who require the most intensive services. The IMPACT Program serves consumers who have historically struggled to be successful in other community settings and who have had frequent hospitalizations. The IMPACT Program supports adults with the most severe and persistent mental illnesses in living successfully in the community and reduces the need for repeated or prolonged psychiatric hospitalizations.

An IMPACT Team is similar to a CARE Team in that it is organized as a mobile group of mental health professionals who merge clinical, medical and rehabilitation staff expertise within one service delivery system. These services are provided regardless of location or frequency to assist the consumer with SPMI in coping with the symptoms of their illness, minimizing the effects of their illness, and maximizing their ability to live independently with minimal periods of psychiatric hospital treatment. IMPACT Programs are required to provide the same services as the CARE Program; however, in order to provide a more intense level of care, services may not exceed a ratio of 12 consumers per one primary therapist. Consumers receive an average of 16 contacts per month, or more, if clinically appropriate, from IMPACT Teams.

Care and IMPACT Program Collaboration with other agencies

CARE and IMPACT encompass health, mental health, rehabilitation, and case management services including services for individuals with co-occurring disorders. CARE/IMPACT staff work with individuals through regular referral/contact with agencies such as Vocational Rehabilitation, alcohol/drug providers, primary care

physicians, and dentists. The CARE/IMPACT teams address needs of consumers on an individual basis and referrals and linkage with other systems are contained within the treatment planning for that individual.

Vocational Coordination

To assist consumers with their employment goals, CARE and IMPACT Programs coordinate services with vocational rehabilitative services as needed. Several community mental health centers have vocational counselors located within their agencies, which allows for increased coordination of services. The Division of Rehabilitation Services funds a program called "Employment Skills Program." The Employment Skills Program provides the individual the opportunity to try various employment occupations, develop work skills, and increase stamina. This is a paid work experience program for individuals diagnosed with mental illness to obtain employment skills in the community. It is a temporary placement of up to 250 hours at a job site. The Division of Rehabilitation Services (DRS) is paying the wages, FICA, and worker's compensation. DRS also purchases services from community mental health centers to provide job development and job supports at the employment placement. The placement and services are coordinated with the community mental health centers to assure the success of the work experience. DRS will also fund tuition fees for individuals with disabilities to further their education through college/trade school attendance.

Educational Coordination

Educational services offered through the CARE and IMPACT Programs include such areas as medications, disability benefits, nutrition and wellness groups, money management, and understanding mental illness and symptom management. Examples of educational services include:

- Community Counseling Services, the Human Service Agency, Lewis and Clark Behavioral Health Services and Southeastern Behavioral HealthCare all utilize a Wellness Curriculum program that provides education to consumers on exercise, nutrition, understanding diagnoses and maintaining a healthy lifestyle.
- The Division of Rehabilitation Services sponsors technical assistance training on disability benefit determinations for individuals with psychiatric disabilities. This training is provided to assist community mental health center staff in understanding SSI and SSDI benefits so they are better prepared in supporting individuals with mental illness in pursuing careers. The trainings are also provided directly to individuals/families receiving mental health services. This has helped to increase the knowledge on employment and its effects on benefits.

The Division of Mental Health and community mental health centers are supportive of individuals returning to school to receive their GED, or pursuing post secondary education. However, there is not currently a funding stream that targets supported education specifically. CARE and IMPACT Teams work closely with the individuals receiving services in identifying educational needs and linking to education services available outside of the community mental health system.

Medical and Dental Service Coordination

The Behavioral Risk Factor Surveillance Survey data from 2003 and 2005 shows that oral health issues among South Dakota adults are significant, and dental disease is exacerbated by various chronic diseases. Among all adults in South Dakota, only 27% had visited the dentist or dental clinic within the past year for any reason. According to the 2005 South Dakota Vital Statistics Report, twenty of the sixty-six counties (30%) in South Dakota do not have a dentist. In addition, only five Federally Qualified Health Care Centers in South Dakota provide dental services to South Dakota communities.

According to the South Dakota Department of Health, Healthcare Workforce Center, over half (60%) of physicians in South Dakota currently practice or reside in urban communities of the state, while only 5.6% practice or reside in rural/frontier communities. There are over 50 Rural Health Clinics across the state; however, there are only six Federally Qualified Health Care Centers in South Dakota providing primary care services.

Due to the shortages of dentists and physicians, especially in the rural and frontier areas of the state, individuals face many challenges in receiving needed healthcare services. CARE/IMPACT Teams work closely with individuals as well as physicians and dentists to assist individuals to necessary primary care services and/or dental services. This includes the sharing of information between mental health and medical/dental providers. In addition, for those individuals living in rural/frontier areas, providers assist individuals in arranging transportation to the closest dental/medical provider. For example, Community Counseling Services in Huron works closely with primary care physicians in the community to share information regarding treatment, medications, etc. This helps to ensure information is shared between the providers and that consumers are receiving quality healthcare for their mental and physical needs.

Housing Coordination and Supports

The Department of Human Services and the South Dakota Housing Development Authority (SDHDA) have a memorandum of understanding (MOU) in place concerning housing for individuals with disabilities. This MOU is a joint policy declaration where the Department of Human Services and the SDHDA agree to consult on acceptable housing options being considered for targeted housing expansion in any community and ensuring those housing options include availability for individuals with disabilities. The Division of Developmental Disabilities, the Division of Mental health, and the Division of Alcohol and Drug Abuse all have appointed liaisons consulting with SDHDA liaisons to review housing applications being considered across the state. This policy ensures individuals with disabilities served by the Department of Human Services have full opportunity to live in integrated settings that match their abilities and interests.

Community mental health centers and the CARE/IMPACT teams work closely with South Dakota Housing Authority, local housing authorities, and property owners to assist individuals in obtaining and maintaining appropriate housing. Due to the shortage of affordable housing across the state, housing support services through community mental health centers are essential components of the community based mental health system.

Housing support actively assists clients in obtaining, moving to, or retaining housing of the client's choice. Support includes providing referrals; actively assisting the client in applying for housing subsidies; assisting the client in appealing a denial, suspension, reduction, or termination of a housing subsidy; and if appropriate, and with the consent of the individual receiving services, providing periodic visits to the client's living arrangements to ensure that the health and safety are being maintained.

Serenity Hills Program

Due to the need for integrated mental health and chemical dependency services, the Division of Mental Health and the Division of Alcohol and Drug Abuse have a cooperative agreement regarding a residential program, to treat individuals with co-occurring disorders through one community mental health center. The Serenity Hills Program is a custodial care facility for adults who are diagnosed with both mental health and substance abuse disorders. It uses a multidisciplinary "integrated" model that combines both mental health and substance abuse treatment within a single, unified, and comprehensive custodial care program. It also includes psychological interventions targeting psychological conditions and chemical dependency issues, especially those that are likely to precipitate relapse or perpetuate the addictive process, which interfere with the client's ability to function independently.

Transitional Housing Services

Residential housing provides room and board for individuals ages 18 and older who have a severe and persistent mental illness, including those with co-occurring substance use disorders, and who, due to their illness, are unable to function in an independent living arrangement. Four of the eleven community mental health centers (Behavior Management Systems, Capital Area Counseling Services, Community Counseling Services, and the Human Service Agency) offer residential facilities. Eighty-one beds are available across the state. Individuals living in Residential Housing are provided the broad range of services available through the CARE or IMPACT Programs. Community mental health centers focus on supporting individuals to develop the skills necessary to live independently and transition into their own apartment.

<u>Assisted Living Centers</u>

South Dakota has two assisted living centers in the state that are organized specifically for individuals with severe and persistent mental illness that also have many medical issues, and need more intense services due to homelessness issues. Funded through the Continuum of Care Grant, and licensed through the Department of Social Services, Cedar Village and Cayman Court are located in the Southeastern part of the state (Yankton and Sioux Falls, respectively). Together, they have approximately a 48-bed capacity, and are operated by the community mental health centers in those areas. All individuals living in these assisted living centers receive CARE services through the community mental health centers.

Discharge Planning between the State Psychiatric Facility and Community

The implementation of a comprehensive, organized, community-based system of services is a key strategy in reducing psychiatric hospitalizations within the State of South Dakota.

The Division of Mental Health and the Human Services Center, the State psychiatric hospital, and the community mental health centers are collaborating to build a seamless system of care as patients leave inpatient hospitalization and move to community-based services. A discharge planning workgroup was created to work on streamlining the discharge planning process to ensure that all individuals, once discharged from the State hospital, are aware of and have immediate access to mental health services in the community. Currently, the group is developing a standard process of information sharing between community mental health centers and the Human Services Center upon admission and discharge. In addition, a better process of assisting individuals with obtaining medications upon discharge has been implemented. This group will continue to meet to address any further areas of concern regarding discharge planning.

Indigent Medication Program

The Division of Mental Health understands the importance of individuals being able to obtain psychotropic medications when they are being discharged from the Human Services Center, a correctional facility, and/or while they are receiving (or waiting to receive) community mental health services. For this reason, the Division of Mental Health continues to support the Indigent Medication Program, which provides temporary funding to assist individuals with little or no finances to purchase their psychotropic medications. In addition, the Division of Mental Health works with community mental health centers to identify pharmaceutical programs that could provide assistance to individuals in obtaining their medications. In FY08, the Division of Mental Health provided funding to 785 individuals who were unable to afford their medications. During FY09, the Indigent Medication Program will continue to provide temporary assistance in obtaining medications for those individuals unable to purchase their psychotropic medications.

Corrections Release Planners

The Division of Mental Health and the Division of Alcohol and Drug Abuse have release planner positions within the corrections system to assist with discharge planning for individuals leaving prison. These Release Planners work closely with community mental health agencies and alcohol and drug providers to develop appropriate release plans for individuals being paroled. The Release Planners also assist parolees in applying for disability benefits, and link to community resources that will assist with housing options, medical needs, and other identified individual needs. This collaboration has assisted in improving successful releases for individuals with severe and persistent mental illness.

South Dakota

Adult - Estimate of Prevalence

Adult - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

The Division of Mental Health serves two primary target populations-adults and children. The target population for the adult system is adults (age 18 or older) with severe and persistent mental illness (SPMI). The definition of SPMI can be found in the Adult Plan, Criterion 1: Available Services.

Based on the WICHE MH Estimation Project, estimates of need for mental health services for South Dakotans with severe and persistent mental illness is 16,765 or 2.9% of South Dakota's population (based on 2006 Census Estimates of population over age 18 being 587,238). In FY08, the Division of Mental Health provided services to 4,727 adults with severe and persistent mental illness. Penetration rates based on prevalence estimates is 28%.

Not all of the estimated 16,765 individuals with SPMI receive services through the public mental health system. Due to the rural/frontier nature of the state, some individuals choose to seek services from primary care physicians. In addition, some individuals seeking community-based mental health services pay for these services from private sources (insurance, etc.). The actual number of individuals needing services from the community based mental health system is not known. The Division of Mental Health is continually working to improve access to mental health care in our state, and is forging key partnerships with primary care and private providers to explore issues related to estimate of need, prevalence, and penetration rates.

South Dakota

Adult - Quantitative Targets

Adult - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

Quantitative Targets

During FY08, the Division of Mental Health provided services to 4,727 adults identified as having severe and persistent mental illness. This total is an increase of 471 individuals over the FY07 total of 4,256. As there has been no new funding for the community mental health system, with the exception of additional funds to address waiting lists, the Division of Mental Health is setting targets for FY09-11 to approximately 1-1.5% higher than FY08. During FY09, it is estimated the Division of Mental Health will provide services to approximately 4,900 individuals with severe and persistent mental illness.

See Adult Plan: Section III: Goals, Targets, and Action Plans for goals and targets to increase access to services for adults with severe and persistent mental illness.

South Dakota

Adult - Outreach to Homeless

Adult - Describe State's outreach to and services for individuals who are homeless

Services to Homeless Populations

Projects for Assistance in Transition from Homelessness (PATH)
Through the PATH Formula Grant Program (P.L. 101-645, Title V, Subtitle B), the Division of Mental Health makes funds available to accredited community mental health centers to provide services to individuals with severe mental illness and/or co-occurring alcohol and drug issues, that are homeless or at imminent risk of homelessness. The allocation amounts are based on the need for services. The urban areas of Sioux Falls and Rapid City have the largest homeless populations; therefore, the need for funding to address the issue of homelessness is greatest in these locations-and they receive the highest allocation amounts.

In order to make the best use of PATH funds, the Division has divided funds into two separate categories. Category 1 is for the provision of direct mental health services. Category 2 funds are used for one-time rental assistance and security deposits. Category 1 funds are made available to provide the following services:

- Outreach services
- Screening and diagnostic treatment services
- Habilitation/rehabilitation services
- Community mental health services
- Case management
- Alcohol/drug treatment services
- Referrals for primary health services
- Job training
- Educational services

Many of the individuals eligible for services under PATH have not historically linked with the community mental health center system or have received limited services due to sporadic utilization. The ability to provide services in a variety of locations and to consumers not tied to a specific funding source assists individuals in accessing the necessary supports in a less intrusive, more comfortable fashion. An additional benefit is the flexibility for staff to monitor consumer status in a non-clinical setting.

Once outreach has occurred, the Homeless Outreach Coordinator engages these individuals and provides services to them through PATH funds. Once there is an opening in the community mental health center's CARE (Continuous, Assistance, Rehabilitation, and Education Program) program the individual is transferred to this program. Prior to this transfer, individuals in the PATH program are linked to mainstream resources just as they would be in the CARE Program. Referrals are made to mental health services, substance abuse services, community health centers, community housing services, vocational rehabilitation services, food stamp programs, Temporary Assistance to Needy Families (TANF), and energy assistance.

The PATH program in Sioux Falls, our largest metropolitan area, provides a Medication Management Program for individuals receiving PATH services. This program utilizes University of South Dakota (USD) Psychiatry residents, overseen by a USD staff

psychiatrist, to provide psychiatric services at no cost to the PATH clients. This program operates one afternoon a week at the local PATH Homeless Outreach Program. PATH clients have seen this program as very beneficial in assisting them in obtaining needed medications, as well as ultimately helping them to become stable enough to locate and secure permanent housing.

Training

In 2008, the Division of Mental Health applied for and received a grant through the PATH National Technical Assistance Center that provided for a Trauma-Informed Care Workshop. This workshop was held in conjunction with the third Annual South Dakota Homeless Summit in the spring of 2008. Kathleen Guarino, Project Manager and Trauma Specialist at the National Center on Family Homelessness provided training on such issues as understanding traumatic stress and creating trauma-informed services and settings for people experiencing homelessness. This opportunity was open for homeless shelters, community mental health centers, state and local agencies, Indian Health Service, school personnel, and many others. Due to the positive response to this training, the Division of Mental Health has asked Kathleen to return and provide a workshop specifically for mental health providers, consumers, and family members. This workshop will again focus on trauma-informed care; however, instead of focusing strictly on homelessness issues, Kathleen will be presenting on trauma informed care in general for all individuals and families receiving mental health services. This workshop will be a part of the annual statewide NAMI conference in South Dakota, being held in October 2008.

Interagency Council on Homelessness (ICH)

In September 2003, Governor Rounds signed Executive Order 03-7 to establish the South Dakota Interagency Council on Homelessness to evaluate and address homelessness issues in South Dakota. Governor Rounds' action supports President Bush's federal Interagency Council initiatives, which were created after it was determined that twenty percent of homeless individuals, those now categorized as chronically homeless, are using eighty percent of the federal funding resources targeted for homeless initiatives.

The Council consists of the Governor; Cabinet Secretaries from the Departments of Health, Human Services, Social Services, Corrections, Education, and Labor; The Adjutant General of Military and Veteran's Affairs; The Director of Tribal Government Relations; and the Executive Director of the South Dakota Housing Development Authority. Department of Human Services Secretary and the Governor's Office co-chair the Council.

The Council is charged with a variety of duties, including identifying and defining homeless issues, determining effective strategies for the prevention of homelessness in South Dakota, providing public education, and working with various advocacy organizations, business, faith-based groups, and consumers regarding policy and program development.

The Council has met many times over the last year, and has identified the following as areas of focus:
(1) Education and work with local homeless programs and shelters to understand various programs;
(2) Evaluation of outreach with state programs, such as regional Department of Social Services offices, including visiting homeless programs and/or shelters and suggesting improvements if needed; and
(3) Outlining a continuum of care for existing programs statewide, and identifying gaps in services/programs.

All activities include both local community service evaluation as well as evaluation of services available on the nine Indian Reservations across the state.

Housing for the Homeless Consortium
The goal of South Dakota Homeless Consortium is to empower homeless individuals and families to regain self-sufficiency to the maximum extent possible by:

- Facilitation of coordination among concerned organizations and individuals
- Facilitation of statewide discussion and awareness of homelessness in South Dakota
- Coordination of projects and grant-writing activities, including the Statewide Continuum of Care Application
- Assessment of the assets and gaps in services/programs to ensure that statewide needs are met (This includes an annual count of homelessness in the state to identify gaps and establish priorities to address those gaps).

The Consortium was formed in January 2001. Involved in the Consortium are private businesses, disability service organizations, local cities/towns, public housing authorities, landlords, formerly homeless individuals, housing developers, regional community action agencies and state agencies, which include the Division of Mental Health. The Consortium meets quarterly to provide opportunities for networking with other providers across the state, problem solve difficult situations, share ideas about "what works," share resource information, and to gain knowledge of new funding opportunities.

In addition, the Consortium gives South Dakota a mechanism to apply for federal homeless assistance funds from the U.S. Department of Housing and Urban Development (HUD). Several projects have been funded through the past 7 years. These include vocational programs, transitional housing programs, South Dakota Network against Family Violence and Sexual Assault, Shelter Plus Care Programs, Emergency Shelter Programs, two assisted living programs, and many others.

The two assisted living programs funded are specifically for homeless individuals, who have a severe mental illness, and medical issues that allow them to meet the necessary level of care. These two facilities have allowed many individuals to receive not only permanent housing, but also community mental health services that are assisting them maintain their housing, as well as build the necessary skills to become more independent if possible.

South Dakota

Adult - Rural Area Services

Adult - Describes how community-based services will be provided to individuals in rural areas

Rural Area Services
South Dakota is predominantly a frontier State with 66 counties and 76,536 square miles. Nine Indian Nations are spread throughout the state and encompass 15,000 square miles. According to 2006 Census population estimates, the population for South Dakota is 781,919. Below is the breakdown of Race/Ethnicity across the State.

Race/Ethnicity	Percent of Population
Caucasian	88.4%
Native American	8.5%
African American	0.9%
Asian	0.7%
Native Hawaiian/Pacific Islander	0.05%
More than One Race	1.4%
Hispanic Ethnicity	2.0%

Thirty-four of the state's counties are classified as frontier (less than 6 persons per square mile) and thirty-one are classified as rural (6 to 99 persons per square mile). Minnehaha County in the southeastern part of the state is considered the only urban (100 or more persons per square mile) county in the state. According to the South Dakota Department of Health, Office of Rural Health, sixty-one of the sixty-six counties in South Dakota are considered mental health professional shortage areas.

Individuals in rural areas receive Continuous, Assistance, Rehabilitative Education (CARE) services (see Criterion 1-Adult Plan), just as those in more urban areas. However, the barriers faced in mental health service provision in the rural areas of the state are numerous and difficult to overcome. Three Rivers Mental Health and Chemical Dependency Center, in the northwest portion of the state provides services to the counties of Corson, Dewey, Harding, Mead, Perkins and Ziebach. This also includes areas of the Standing Rock and Cheyenne River Sioux Nations. Southern Plains Behavioral Health Services in the south central region of South Dakota covers the counties of Gregory, Mellette, Todd and Tripp. The Rosebud Sioux Nation is also included in this area. The rural nature of each of these service areas poses some unique challenges in delivery of mental health services. To assist in addressing access to care issues such as lack of transportation and financial resources, CMHCs have established satellite offices in rural areas of their catchment areas and are committed to providing services in the person's home or community.

The Division of Mental Health implemented a rural rate for CARE services that is 20% higher than the regular rate to help address higher expenses due to travel time and non-billable staff time when delivering mental health services. Community mental health centers are reimbursed at the rural rate for any services provided twenty miles from a main or satellite office. Because the entire catchment area of Three Rivers Mental Health Center is in one of the most rural area of the state, this center utilizes the rural rate for all CARE services provided throughout their catchment area.

Psychiatry services in the rural and frontier areas of the state pose a significant challenge to providing a broad continuum of care. Often psychiatrists are not willing to live and work in these rural and frontier areas, and contracting with those who are willing is very expensive for mental health providers. In working to develop a solution to the shortage of psychiatric services in rural areas, the Division was successful in lobbying the South Dakota Office of Medical Services, Department of Social Services, to include telemedicine as a reimbursable service. Using broadband bi-directional video conferencing, psychiatrists can interact with patients at distant locations. Telemedicine has played an important role in improving access to mental health care in rural/frontier areas of the state.

South Dakota

Adult - Older Adults

Adult - Describes how community-based services are provided to older adults

Services to Older Adults

The number of older adults and their needs for mental health services and supports is increasing rapidly in this country. South Dakota is steadily becoming a haven for retirees, with an estimated 14.3 percent of its population comprised of older adults, compared to 12.4 percent on average across the nation (according to Census information, Centers for Disease Control data, Department of Social Services data, and the South Dakota Economic Development Plan).

A significant number of older adults experience serious mental illness that remains unrecognized and untreated. The rural/frontier nature of South Dakota, stigma, and lack of knowledge about mental health services may keep many older adults from seeking treatment.

The Division of Mental Health's expectation is that community mental health centers provide an array of mental health services that meet the needs of all populations of adults. These services are consumer/family driven, recovery-oriented, and provided in the least restrictive environment possible. All individuals, including older adults, eligible for services through the Division of Mental Health have access to the same services outlined in the Adult Plan, Criterion 1: Available Services section of this Block Grant.

Community mental health centers across the state coordinate with assisted living centers and nursing homes to provide mental health services to individuals residing in these facilities. For example, Community Counseling Services in Huron provides counseling services in eight nursing homes in their catchment area, support to home health care staff, and work with senior centers to develop behavioral health supports for elderly living in the community. Lewis and Clark Behavioral Health Services in Yankton also contracts with a number of nursing homes across their catchment area to provide mental health and psychiatry services.

Two community mental health centers also operate assisted living centers specifically for individuals with mental illness, high medical concerns, and past issues of homelessness. Southeastern Behavioral HealthCare in Sioux Falls has Cayman Court-a 24 bed assisted living facility. Lewis and Clark Behavioral Health Services in Yankton has Cedar Village-also a 24 bed assisted living facility. Both facilities offer CARE services (adult mental health services) as well as psychiatry services.

The Division of Mental Health and the Department of Social Services, Division of Adult Services and Aging, collaborate to assure that individuals with mental illness are appropriately placed in nursing homes. The Preadmission Screening and Resident Review (PASRR) process helps to identify people with serious mental illnesses either who meet qualifications for a higher level of care, such as a nursing home, or who can be more appropriately served in the community in a more independent living situation.

In addition, the Division reviews the Geriatric Unit at the Human Services Center on an annual basis. This review is to ensure individuals on the unit remain appropriate for

inpatient placement, or to determine if nursing home placement or other less restrictive environments should be sought.

In 2008, the Division of Mental Health, the Division of Alcohol and Drug Abuse, the Division of Adult Services and Aging, Indian Health Services, community mental health centers, and the Front Porch Coalition participated in a survey sent out by the SAMHSA Technical Assistance Center. This survey gathered information that assisted in the development of a Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis for the state to begin identifying and addressing gaps in services for older adults.

In June 2008, the Division of Mental Health, the Division of Alcohol and Drug Abuse, the Aberdeen Area Indian Health Services, and the Division of Adult Services and Aging participated in a SAMHSA Technical Assistance Center sponsored workshop titled, *"Strengths, Weaknesses, Opportunities, and Threats (SWOT): Preparing to Meet the Needs of Older Adults."* The SWOT assessment developed from the surveys submitted back to SAMHSA was shared with all state stakeholders. The Division of Mental Health will work with all stakeholders to use the SWOT assessment as a resource towards improving services for older adults.

South Dakota

Adult - Resources for Providers

Adult - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

Resources for Providers

Financial Resources

Targeted amounts in the FY09 budget specifically for children with serious emotional disturbances are $8,851,928. Funding includes Medicaid, block grant, and state general funds. Included in this budget are services provided through the SED program. The entire community-based budget is $22,456,183 and includes services to individuals with severe and persistent mental illness (SPMI), children with serious emotional disturbance (SED) as well as other services such as outpatient, emergency, protection and advocacy, and the Indigent Medication Program. Expenditure and utilization data is provided to the Mental Health Planning and Coordination Advisory Council at their quarterly meetings.

The State of South Dakota provides medical and mental health services to a large number of children eligible for Medicaid. The Department of Social Services' (DSS) budget includes a federally mandated State general fund match to federal Medicaid dollars to provide medical services to children that are Medicaid eligible. In an agreement established through a memorandum of understanding with DSS, the DMH budget includes a federally mandated State general fund match to federal Medicaid dollars to provide mental health services to children that are Medicaid eligible. Through funding provided by the State Children's Health Insurance Program (CHIP), South Dakota's Medicaid program has expanded to cover all children under 19 whose families' incomes are at or below 140% of the federal poverty level. In addition, CHIP-NM has been created to allow families, who are not eligible for Medicaid or CHIP and whose incomes are at or below 200% of federal poverty level, to qualify. Each community mental health center has made it a priority to educate families on the eligibility criteria and application process for CHIP, as well as the overall advantages to being involved in the program.

Children's SED services, which include psychiatric services provided by a psychiatrist or Certified Nurse Practioners/Physician Assistants are funded through a fee for service paid for every fifteen minute unit of service. One of the main priorities of the Division of Mental Health is to provide access to services in the most rural/frontier areas of the state. Despite no additional funding being allocated, the Division in was able to include a rural rate for services provided 20 miles from a main or satellite office. This rural rate, which is 20% higher than the standard SED rate, enhances access to funding for centers in rural and frontier areas with higher expenses due to travel time and non-billable staff time. Due to their entire catchment areas being in frontier areas of the state, Three Rivers Mental Health Center in Lemmon and Southern Plains Behavioral Health Services in Winner use the rural rate for all mental health services delivered to children with SED. Emergency services are also provided through purchase of services agreements with the eleven community mental health centers.

Current rates for services will be evaluated as part of an ongoing process. The Division of Mental Health will provide ongoing training addressing rate change issues, changes in current procedural terminology (CPT) codes, and making our systems compliant with HIPAA requirements.

The Division of Mental Health uses MIS data to monitor contract and Medicaid Expenditures. Expenditure and utilization data is then shared with the Mental Health Planning and Coordination Advisory Council during their quarterly meetings.

Services to Veterans

Due to the high incidence of mental disorders for veterans returning from Iraq, and the high number of National Guard Units in South Dakota, the Council of Mental Health Centers and the Division of Mental Health are collaborating with the South Dakota National Guard to provide mental health services to these veterans returning from Iraq and their families. Provision of these services has been very helpful to vets and their families, especially those living in the most rural/frontier areas of the state where access to mental health services is limited.

Management Information Systems

The Division of Mental Health and the Division of Alcohol and Drug Abuse share a management information system. The State Treatment Activity Reporting System (STARS) allows both Divisions the capacity to collect important data on the National Outcome Measures as well as on state specific performance indicators. Community mental health centers provide data for STARS either through direct entry, or batch loading from their information systems into STARS. STARS collects information on demographics of individuals served, as well as service utilization. Information collected in STARS is invaluable to the preparation of Block Grant goals and objectives as well as the Uniform Reporting System (URS) Tables.

Evaluation of Services

On an annual basis, the Division of Mental Health conducts Mental Health Statistic Improvement Program (MHSIP) Surveys with individuals receiving services through the community-based mental health system. Participants include adults with severe and persistent mental illness, youth (14-18) with serious emotional disorders, and families of children (0-18) with serious emotional disorders. The Western Interstate Commission for Higher Education (WICHE) pulls a random sample of individuals that have received a service within the three months prior to drawing the sample. The survey provides data on participation in developing the treatment plan, improved functioning, improved social connectedness, criminal justice involvement, culturally appropriate services provision, and overall satisfaction with the mental health services. WICHE compiles the data and provides a report back to South Dakota that is shared with the community mental health centers. This survey and evaluation is assisting in transformation of the community mental health system to be recovery-oriented and consumer driven.

Training opportunities

Qualified Mental Health Professional Training

To ensure the involuntary commitment process for children is being handled appropriately, the Division of Mental Health offers a Qualified Mental Health Professional (QMHP) Endorsement, which allows qualified individuals to perform the mental health status examination prior to the involuntary commitment of children. Licensed Social Workers, Marriage and Family Therapists, Licensed Professional

Counselors, Psychologists, and Psychiatric Nurses/Certified Nurse Practioners qualify to become endorsed as QMHPs. The availability of so many professions having the ability to be endorsed assists South Dakota in overcoming rural issues of the state when individuals are faced with involuntary commitment. The QMHP training includes information on the following:

- Involuntary Commitment Process
- Mental Health Status Examination
- South Dakota Laws relative to inpatient hospitalization
- Hearing Procedures for QMHP's in the commitment process of a child

Recovery and Peer Support Training

In FY08, The DMH consulted with the Depression and Bipolar Support Alliance (DBSA), in conjunction with the National Association of State Mental Health Program Directors (NASMHPD's) National Technical Assistance Center, and with support from SAMHSA's Center for Mental Health Services to sponsor a Transformation, Recovery, and Peer-Support Institute (TRPSI). This consumer-run institute took place in fall of 2007 as part of the annual South Dakota NAMI conference. South Dakota consumers, family members, and community mental health providers gathered to build plans together to make recovery real in South Dakota. Workshop sessions included training on:

- Building partnerships to cooperatively transform Mental Healthcare in South Dakota
- How Self-Help / Peer Support can be used to support the traditional mental health system
- What is Peer Support and how to make it a reality
- Advocacy Thru Self-Help / Peer Support
- Growing Your Grassroots Organization
- The Emerging Movement of Consumers as Providers
- Planning for Transformation in South Dakota
- Beyond Stabilization: Recovery-Orientation for Providers
- Creating a Statewide Recovery Network

Systems of Care and Integrated Treatment Training and Development

In June 2008, the System of Care (SoC) Pilot Project at Behavior Management Systems in Rapid City held a Search Conference. All community mental health centers, local/regional service agencies (Department of Corrections, Department of Social Services, Department of Education, and Unified Judicial System), and family members were invited to attend the conference to learn more about SoC development and implementation. Topics discussed at the conference included analysis of the human service system, the environment of the community, and integration of the system and environment through strategic planning and diffusion of the plan.

Another important component of systems of care is development of wrap-around services. Wraparound is a family centered, individualized way to reach out to families with complex, unmet needs. It is about meeting needs and producing results that reflect a family's culture, priorities, and values. As part of the SoC Pilot Project, Behavior Management Systems has purchased a Wraparound Curriculum and videotape training.

This particular curriculum was chosen after extensive research on behalf of WICHE. National SoC experts endorsed these training materials, including faculty at the University of South Florida, Mental Health Institute. Behavior Management Systems is starting to utilize this curriculum, and next steps will include additional training. Identification of needs and priorities will drive the development of a training plan and time for delivery.

Change Agents within community mental health centers and alcohol and drug providers are receiving training on Integrated Longitudinal Strength-Based Assessments (ILSA), treatment planning, screening and identification of individuals with co-occurring disorders, and how to build integrated care into the system. Strength-based, comprehensive assessments will aide providers in developing individualized plans of care for individuals with mental illness. Upcoming trainings over the next year will include a workshop on SAMHSA's Tip 42: Substance Abuse Treatment for Persons with Co-Occurring Disorders; additional lecture and demonstration on development of ILSA; and, formulation and treatment planning for individuals with co-occurring disorders.

Suicide Prevention and Intervention Training

As part of the State/Tribal Youth Suicide Prevention and Intervention Grant, community mental health center staff are participating in various trainings for suicide prevention and intervention. To date, over 1,000 individuals statewide have received training on suicide prevention and intervention. These individuals include community members, caregivers, mental health/alcohol drug providers, family members, school staff, law enforcement, child welfare staff, and university staff/students. Trainings have included:

- Applied Suicide Intervention Skills Training (ASIST). ASIST is a 2-day workshop designed to teach the skills to intervene with an individual at risk of suicide. Developed by LivingWorks Education, Inc., the workshop prepares gatekeepers to build a local "safety net" for those at risk.
- SafeTALK is a LivingWorks' program that trains community members to recognize persons with thoughts of suicide and connect them to suicide intervention resources.
- Working Together, a program developed by LivingWorks, is a one-day learning experience for community helpers/members. It is designed to help community members bridge gaps within their communities to increase support for persons at risk for suicide.
- Lifelines is a school-based suicide prevention curriculum. The topics of the lessons include attitudes about suicide, warning signs of suicide, school resources and role-playing exercises for students. The program also includes school-based model policies and procedures for responding to at-risk youth, suicide attempts, and completions; presentations for educators and parents; and a one-day workshop to train teachers to provide the curriculum. LifeLines is being taught to eighth and ninth graders at the 25 high schools identified as part of the Suicide Prevention and Intervention Grant.

The Division, in partnership with Sinte Gleska University and Wakanyeja Pawicayapi, Inc., is offering cultural awareness trainings to all mental health providers, community

members, and caregivers, specifically on Lakota culture, history of trauma, and Lakota mental health and wellness beliefs. Thirty trainings over a three-year period are offered in different communities across the state. These trainings assist community mental health centers in incorporating cultural sensitivity into the services provided to youth and families. In addition to these trainings, the Division of Mental Health works with the Advisory Council and the community mental health centers to identify further needs in implementation of a culturally competent, integrated system of care.

Other areas of training

Other areas the Division of Mental Health and the community mental health centers are working together to provide clinician training:

- Rural Mental Health Grand Rounds Web casts through WICHE are available to all community mental health providers. Topics have included Rural Evidence Based Practices, Collaborative Health Care, Telemedicine, Screening and Intervention, and Developing Cultural Awareness and Culturally Competent Services.

South Dakota

Adult - Emergency Service Provider Training

Adult - Provides for training of providers of emergency health services regarding mental health;

Emergency Service Provider Training

Crisis Counseling

The Division of Mental Health, through Regular Services Program Grant, closed out in summer 2007, provided assistance to individuals and families affected by flooding in the Northeastern region of the state. This Grant funded the "Caring Hands" crisis counseling team, which was located in Aberdeen, South Dakota. Caring Hands was a group of local individuals who spent their time conducting door-to-door outreach, community education groups on recovery from disasters, and working with area senior centers providing disaster education. The program was a very successful example of disaster response in a rural area, and considered a valuable learning tool to all involved.

In addition, due in large part to a 2006 Emergency Response Grant, South Dakota was able to build the emergency response capacity of mental health and alcohol/drug personnel, as well as hospitals, emergency medical technicians, and other first responders in communities. Trainings in the Critical Incident Stress Management (CISM) model and the development of South Dakotans ability to be CISM trainers has allowed the state to continue these efforts over the last few years. The Division continues to work with the Office of Emergency Management and other state agencies to ensure first responders are able to respond appropriately to mental health emergencies.

Local Provider Trainings

Community mental health centers provide numerous trainings for emergency service providers on local levels. Below is a list of community mental health centers and the trainings provided in their communities:

- Community Counseling Services (CCS) in Huron conducted a four-hour training for the Huron Police Department on law enforcement interventions with individuals with serious mental health issues. CCS staff also conducted trainings and provided services to the police department and the ER staff of the local hospitals on critical incident debriefing.
- Dakota Counseling Institute in Mitchell provides an annual training to law enforcement officers on mental health issues in general with specific emphasis on suicide and involuntary versus voluntary commitments.
- The Human Service Agency (HSA) in Watertown conducts six trainings/year on interacting with people with mental illness to the Watertown Police Department. All police personnel are required to attend. In addition, the Executive Director of HSA conducts a two-hour in-service on stress management to the Watertown Fire Department on an annual basis.
- The Executive Director of Lewis and Clark Behavioral Health Services (LCBHS) in Yankton is the Clinical Director for the Missouri valley Critical Incident Stress Management Team (CISM). The CISM team participates in quarterly meetings with emergency medical staff (EMS) and law enforcement to train on mental health related issues. In addition, LCBHS staff conducts training for the local police and the sheriff's office on an annual basis. LCBHS also hosts an annual

Mental Health Awareness Conference that offers sessions on mental health and law enforcement issues.

- Northeastern Mental Health Center (NEMHC) clinicians provided training in debriefing techniques to the county emergency response team in the Aberdeen community. Northeastern staff also presented a workshop on the Stigma of Mental Illness to consumers, human service providers, and family members.
- Southeastern Behavioral HealthCare (SEBHC) in Sioux Falls has provided trainings to local law enforcement and jail personnel on mental health issues, and detecting and preventing suicides of individuals within the jail system.

Law Enforcement Training

In an effort to build awareness and provide information on mental illness, the DMH contracts with a consumer to present the "In Our Own Voice" Program to provide training and information to law enforcement officers during Law Enforcement Academy Training. The Division of Mental Health, along with the Department of Human Services Legal Council, and this consumer conduct this training on a quarterly basis. This course gives law enforcement officers a better understanding of mental illness and application of this knowledge when in the field.

Primary Care Physician Training

In spring 2007, the Division of Mental Health was awarded a Wellmark Foundation Grant to address treating of depression by primary care physicians. This was a collaborative effort between the Health Care Commission's Sub-Committee on Mental Illness and Depression, the Division of Mental Health, the South Dakota Council for Mental Health Centers, and the Western Interstate Commission for Higher Education (WICHE) Mental Health Program. There were three overarching activities to the project: training, implementation, and monitoring.

- Training was provided to primary care and mental health providers from nine Federally Qualified Health Centers (FQHCs). Specifically, participants learned the process of detecting, diagnosing, treating, and monitoring patients with depression based on materials from the *MacArthur Initiative on Depression in Primary Care*. This is an evidence-based program that is consistent with national guidelines on treating depression.
- Monitoring involved direct tracking of symptoms by a treating physician and other primary care staff or working with mental health providers collaboratively.
- The implementation phase involved working directly with primary care staff to incorporate the measures, processes, protocols, and other aspects of training into their daily work. This included on-site visits, analysis of current processes, and collaboration on how best to include these instruments and procedures without unduly increasing the burden on primary care providers. It also involved getting feedback on problems that arose and how to address them.

South Dakota

Adult - Grant Expenditure Manner

Adult - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

Grant Expenditure Manner

In the reporting requirements for Table C: Funding for Transformation Activities, the Division of Mental Health does not have the capability to break out transformation expenditure data as requested. The Division, however, does want to assure CMHS that transformation activities are included in the current budget set forth for the community based mental health delivery system. In addition, the Division works closely with the CMHCs and the Advisory Council to implement transformation activities as is apparent throughout the Block Grant application.

Through purchase of service agreements with eleven non-profit CMHCs, the Division of Mental Health provides services to individuals. The Block Grant funds will be allocated to services for individuals with severe and persistent mental illness receiving services through CARE, as well as adults receiving services through Serenity Hills, the only state residential treatment program for individuals with co-occurring disorders. See Adult Plan, Section III, Criterion I, Available services for a description of CARE.

The criteria for identification as an individual with severe and persistent mental illness is indicated by at least (1) of the following:

- Has undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime.
- Has experienced a single episode of psychiatric hospitalization with an Axis I and/or Axis II diagnosis per the DSM-III-R or DSM-IV.
- Has been maintained with psychotropic medication for at least one year.
- Has frequent crisis contacts with a CMHC for more than six months as a result of severe and persistent psychiatric symptomatology.

In addition, the individual must have impaired role functioning as indicated by at least three (3) of the following:

- Is unemployed or has markedly limited job skills and/or poor work history.
- Is unable to perform basic living skills without assistance.
- Exhibits inappropriate social behavior that results in concern by the community and/or request for mental health services by the judicial/legal systems.
- Is unable to procure appropriate public support services without assistance.
- Requires public financial assistance for out of hospital maintenance.
- Lacks social support systems in a natural environment.

Serenity Hills is a custodial care facility for adults who are diagnosed with a mental health disorder and a substance abuse disorder. This program uses a multidisciplinary "integrated" model that combines both mental health and substance abuse treatment within a single, unified, and comprehensive custodial care program. The Serenity Hills Program includes developing skills on abstinence, acceptance of the nature of chemical dependency, and utilization of self-help groups for support and maintenance. It also includes psychological interventions targeting psychological conditions and chemical dependency issues, especially those that are likely to precipitate relapse and which may interfere with the client's ability to function independently.

The Serenity Hills Dual Diagnosis Program must meet all of the requirements in the Administrative Rules from the Division of Alcohol and Drug Abuse for a "Clinically-Managed Low-Intensity Residential Treatment Program". Enrollment in the program for consumers being partially funded by the Division of Mental Health is limited to adults who meet eligibility criteria for severe and persistent mental illness (SPMI). Additionally, the program provides psychological evaluations, medication management, and routine psycho-education by a psychiatrist, licensed psychologist, registered nurse, and counseling staff. Some of these services include:

- Screening/evaluation, group and/or individual therapy, and psycho-education
- Case Management
- Crisis Assessment and Intervention
- Symptom Assessment and Management Medication Prescription, Administration, Monitoring, and Documentation
- Direct Assistance – to ensure that the consumer obtains the basic necessities of daily life and performs basic daily living activities
- Development of Psychosocial Skills
- Family Participation

FY08 INTENDED USE PLAN

The South Dakota Division of Mental Health (DMH) received notification on April 1, 2008 from the Center for Mental Health Services that the approved FY08 budget included a decrease in mental health block grant funding totaling $30,308 for South Dakota. In response to this decrease, the Division of Mental Health modified the FY08 intended use plan to reflect the new funding level.

As stated in the FY08 State Plan, the Division of Mental Health allocates Block Grant funds towards services to adults with SPMI and children with SED. Section 1913 (a) of the PHS Act (42 USC 300x-3) requires that the State provide systems of integrated services for children with serious emotional disturbances (SED). Furthermore, the Block Grant states that each year, the State shall expend not less than the calculated amount for the Fiscal Year 1994. The FY08 intended use plan includes this level of funding for children's services. Therefore, the $689,452 allocated towards SED Children's Mental Health Services will remain at that level, and the decrease of $30,308 is addressed through administration and SPMI adult funding levels. Administration expenses were recalculated based on the new block grant funding level, as was each of the community mental health centers' SPMI adult mental health services amount. In the original FY08 Block Grant application, the Division of Mental Health planned to allocate funding for both children with SED and adults with SPMI to each community mental health center. Due to decreased levels of CMHS Block Grant funding over the last three years, the Division of Mental Health simplified the process of allocation of Block Grant funds related to services for adults with SPMI. Three community mental health centers receive CMHS Block Grant allocations to be applied towards services for adults. All eleven community mental health centers continue to receive Block Grant funds for services to children with SED. Funding for services to adults with SPMI at the remaining eight community mental health centers is allocated through State General funds and Medicaid

dollars; therefore, all centers will continue to receive funding for services to children with SED and adults with SPMI.

The following is a list summarizing the activities that the FY08 CMHS Block Grant will fund:

Administration	$ 42,422
SPMI Adult Mental Health Services	$116,564
SED Children's Mental Health Services	$689,452
Total	$848,438

Block Grant Funding for each of the 11 community mental health centers will be as follows:

Community mental health center	Adult SPMI	Children's SED	TOTAL
Behavior Management Systems	23,610	186,152	209,762
Capital Area Counseling	0	41,367	41,367
Community Counseling Services	0	41,367	41,367
Dakota Counseling Institute	0	62,050	62,050
East Central Mental Health Center	0	6,895	6,895
Human Service Agency	43,800	55,156	98,956
Lewis & Clark Behavioral Health Services	49,154	103,418	152,572
Northeastern Mental Health Centers	0	68,945	68,945
Southeastern Behavioral HealthCare	0	75,840	75,840
Southern Plains Behavioral Health Services	0	27,578	27,578
Three Rivers Mental Health Center	0	20,684	20,684

The decrease in funding for services to adults with SPMI was a total of $28,794. The Block Grant allotment for South Dakota has seen decreases consistently over the last three years, with the FY08 allotment being the largest decrease to date. Based on the FY08 target regarding the average amount of public funds expended on mental health services for adults with SPMI, this decrease will affect approximately eleven individuals.

Table C. MHBG Funding for Transformation Activities
State: South Dakota

	Column 1	Column 2	
	Is MHBG funding used to support this goal? If yes, please check	If yes, please provide the *actual* **or** *estimated* amount of MHBG funding that will be used to support this transformation goal in FY	
		Actual	**Estimated**
GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health	☐		
GOAL 2: Mental Health Care is Consumer and Family Driven	☐		
GOAL 3: Disparities in Mental Health Services are Eliminated	☐		
GOAL 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice	☐		
GOAL 5: Excellent Mental Health Care Is Delivered and Programs are Evaluated*	☐		
GOAL 6: Technology Is Used to Access Mental Health Care and Information	☐		
Total MHBG Funds	N/A	0	0

*Goal 5 of the Final Report of the President's New Freedom Commission on Mental Health states: Excellent Mental Health Care is Delivered and Research is Accelerated. However, Section XX of the MHBG statute provides that research … Therefore, States are asked to report expected MHBG expenditures related to program evaluation, rather than research.

South Dakota

Table C - Description of Transformation Activities

For each mental health transformation goal provided in Table C, breifly describe transformation activities that are supported by the MHBG. You may combine goals in a single description if appropriate. If your State''s transformation activities are described elsewhere in this application, you may simply refer to that section(s).

Description of Transformation Activities

In the reporting requirements for Table C: Funding for Transformation Activities, the Division of Mental Health does not have the capability to break out transformation expenditure data according to New Freedom Commission Goals. All funding received through the Block Grant is utilized in direct service provision to adults with severe and persistent mental illness and children with serious emotional disorders. Services provided include focus on the goals of the New Freedom Commission Report; however, the Division cannot break out expenditures to specific activities.

As South Dakota's Block Grant allotment has decreased consistently over the last few years, with the largest decrease occurring last year ($30,000), and no additional funding from the state to support transformational activities, the Division of Mental Health has had to fund transformation activities through current state budget constraints. This has been very challenging for the Division of Mental Health and the community mental health system. However, the Division of Mental Health, the Advisory Council, and the community mental health centers have prioritized transformation of the community system to a system that is individualized, recovery-oriented, consumer/family driven, and provided through an integrated system of care. Even with the challenges faced by lack of funding, all stakeholders are committed to these transformation efforts.

As stated throughout the Block Grant application, the Division of Mental Health, community mental health providers, and the Mental Health Planning Council have made a major commitment to transform the delivery of services to individuals and families in the public mental health system. Transformation of the community mental health system includes the development of integrated treatment to promote recovery and resiliency delivered in a consumer/family driven system of care.

Included throughout transformation activities is development of culturally aware and competent services.

As identified by the Advisory Council, the President's New Freedom Commission Goals and Recommendations that are integral to transformation activities in South Dakota are as follows:

- Goal 2: Mental Health is Consumer and Family Driven
  - 2.1 Develop an individualized plan of care for every adult with a serious mental illness
  - 2.2 Involve consumers and families fully in orienting the mental health system toward recovery
- Goal 4: Early Mental Health Screening, Assessment, and Referral to Services are common practice
  - 4.4 Screen for co-occurring mental health and substance use disorders and link with integrated treatment strategies.
- Goal 5: Excellent Mental Health Care is Delivered and Research is Accelerated
  - 5.3 Improve and expand the workforce providing evidence-based mental health services and supports.

Many of these priorities will require multiple years to implement as described throughout this Block Grant Application. The Division also identifies that the transformation process involves system change efforts that include partnerships in service quality improvement that welcomes, includes, and empowers all levels of the system, including consumers, families and other stakeholders. This CQI change process includes mental health, alcohol and drug, and developmental disability services in all aspects of development. Regional partnerships between services and agencies to facilitate the creation of an integrated and collaborative system are also very important pieces involved in transformation activities. Included throughout the transformation process is a focus on provision of services that are culturally responsive to individuals needs/wants.

Recovery orientation and Peer Support

To support South Dakota in transformation efforts, the Depression and Bipolar Support Alliance (DBSA), in conjunction with the National Association of State Mental Health Program Director's (NASMHPD) Technical Assistance Center, and with support from SAMHSA's Center for Mental Health Services, sponsored a Transformation, Recovery, and Peer-Support Institute (TRPSI). This consumer-run institute took place in October 2007, in conjunction with the South Dakota National Alliance on Mental Illness (NAMI-SD) annual conference. South Dakota consumers, family members, and mental health providers gathered to network and learn how to make recovery and peer support a reality for South Dakotans.

The Division of Mental Health is also working with SDUnited, the newly formed consumer advocacy group, to bring the National Empowerment Center (NEC) to our State. The NEC will provide in-service trainings to community mental health providers that will include additional information on recovery and how to coordinate mental health services with consumers that allows them to drive services/treatment and develop plans that will assist them in reaching their recovery goals. Consumers and family members initiated this activity and will be involved in the trainings. This will be an ongoing partnership over the next few years, as our system moves forward.

The Division of Mental Health and the Assertive Community Treatment Programs within the state are now measuring fidelity and using the Assertive Community Treatment Toolkit to assist in improving mental health services provided to individuals requiring a more intense level of service. In addition, the Division of Mental Health and the community mental health centers are also looking at the Illness Management and Recovery and the Family Psycho-education Toolkits for implementation into services provided to adults with mental illness.

Systems of Care for Children and Families

The Children's System of Care Steering Committee was formed in order to assist in building a system of care that crosses service sectors and deconstructs barriers to holistic services offered in the least restrictive settings possible. Representation on the Steering Committee includes the Departments of Human Services, Social Services, Corrections, and Education; and the Unified Judicial System. As part of building systems of care, in

2007, the Children's System of Care Steering Committee developed an RFP for implementation of a Systems of Care (SoC) Pilot Project, which seeks to:

- Develop and implement a project in the Rapid City area to provide family-driven, youth-guided, community-based, and culturally and linguistically competent services to children, youth, and their families;
- Promote consensus-building activities among appropriate agencies, organizations, and family members to develop a shared vision and strategic plan for designing, implementing, and evaluating system of care infrastructure and services;
- Develop a full array of services that meet or exceed specified quality assurance standards for these children and their families in collaboration with service providers and other state agencies;
- Develop a competent workforce through the provision of training on essential components within the system of care framework, such as wraparound development and the delivery of evidence-based practices; and
- Evaluate the outcome of the project with the goal of implementing successful elements into a statewide behavioral services delivery system.

As one component of this project, the Western Interstate Commission for Higher Education (WICHE) Mental Health Program conducted a community readiness assessment of key stakeholders in Rapid City. Community readiness evaluations identify specific characteristics related to different levels of problem awareness and readiness for change in a given community. Rapid City's community was described as open-minded, generous, and receptive to new ideas and changes. Overall, Rapid City fell into the beginning stages of community readiness, which involved recognition of the issue as a problem and an understanding that the existing leadership is in need of assistance to develop a plan of action. The Rapid City Pilot Project leaders identified that parent partnerships were necessary to create an effective system of care, and invited parents to join the project. Additionally, Pilot Project stakeholders are in the process of recruiting a group of parents to ensure discussions and recommendations from parent leaders encompass representation of the cultural diversity reflected in the community and state.

In 2008, the SoC Pilot Project included a Family Welcoming Meeting and Search Conference. Barbara Huff of the Federation of Families, in conjunction with SD Advisory Council Chair, Amanda Lautenschlager, partnered with the Pilot Project Team to officially welcome families to partner with providers in system of care development and planning. At the meeting, families shared their concerns and needs regarding services, and identified how they could participate at the local and State levels.

The Family Welcoming Meeting was immediately followed by a Search Conference, facilitated by WICHE consultant, Richard Mettler. The Search Conference, entitled,

Expanding Partnerships: The Future of Integrated Services for Children and Families, was held in Rapid City with the goal of developing a specific action plan and exploring necessary components of an effective system of care (including how it will function and steps to achievement). Professionals from different agencies and disciplines, families of consumers, and community members participated in conference activities.

The purpose of the Search Conference was to identify strategies and create an action plan toward the integration of systems (behavioral health and other necessary systems) into a coordinated network to meet the multiple and changing needs of children and their families. The importance of cultivating partnerships between parents and professionals was also addressed. The Search Conference participants agreed to prioritize family-driven care (i.e., families have a primary decision making role in the care of their children, as well as the policies and procedures governing care for all children in their community, State, Tribe, territory, and nation).

The System of Care Pilot Project also includes the application of an effective, reputable Wraparound Curriculum. Wraparound is a family centered, individualized way to reach out to families with complex, unmet needs. It is about meeting needs and producing results that reflect a family's culture, priorities, and values. As part of the SoC Pilot Project, Behavior Management Systems has purchased a Wraparound Curriculum and videotape training. This particular curriculum was chosen after extensive research on behalf of WICHE. National SoC experts endorsed these training materials, including faculty at the University of South Florida, Mental Health Institute. Behavior Management Systems is starting to utilize this curriculum, and next steps will include additional training. Identification of needs and priorities will drive the development of a training plan and time for delivery.

Integrated Treatment for Individuals/Families with Co-occurring Disorders

Activities related to integrated treatment received a major boost when South Dakota was awarded the COSIG grant in 2007. The Division of Mental Health (DMH), the Division of Alcohol and Drug Abuse (DADA), and the Human Services Center (HSC-state inpatient psychiatric facility) have collaborated with providers in developing a statewide quality improvement process for engaging every program in transformation efforts to become a welcoming, recovery-oriented, integrated system of care for all individuals, including those with co-occurring disorders. The COSIG grant has provided resources at both the state and agency level to support efforts in developing core Comprehensive Continuous Integrated System of Care (CCISC) infrastructure for implementation of integrated services.

The DMH, the DADA, HSC, the Council of Mental Health Centers and the Council of Alcohol and Drug Providers Executive Director, and the Project Coordinator have formed a Leadership Team. This team identifies and sets priorities for the implementation of integrated treatment. In addition, there is an operating core team with the Project Coordinator and one lead person from the DMH and the DADA, to help to organize key implementation activities. DMH and DADA staff have begun participating in joint meetings, both with the Consultants (Drs. Minkoff and Cline), and on agency technical

assistance visits. Next objectives include regular joint meetings of DMH/DADA leadership with clinical directors from both mental health and addiction providers, as a locus for integrated services planning system wide.

During the course of the last year, language supporting integrated treatment and encouraging implementation of the CCISC quality improvement process has been included in the DMH contracts with community mental health centers. As a result, the Division of Mental Health has achieved full participation from all community mental health centers. All community mental health centers have completed program self-assessments, and received at least one on-site technical assistance visit from Drs. Minkoff and Cline.

In addition, as part of implementation of the CCISC model, community mental health centers and alcohol/drug providers have assigned Change Agents from each of their respective agencies to drive implementation of integrated services from the local levels. Change Agents across the state reflect a wide diversity of clinicians from many backgrounds and services, including Native American services and prevention services. The role of Change Agents in their local programs includes provision of training and supervision on the principles of the CCISC model and program consultation to facilitate development and implementation of quality improvement action planning to establish and enhance dual diagnosis capability in the programs as a whole. These individuals meet on a regular basis as a statewide group to discuss integration of services, receive training on areas such as welcoming attitudes/policies, strength-based treatment, and screening and assessment. This is giving Change Agents some concrete tools to take back to their programs for shifting not only practice, but documentation as well.

Next steps in integrated treatment implementation include:

- Develop mechanisms on incorporating the CCISC model and principles into assessments, case discussions, and treatment plans.
- All mental health providers and alcohol and drug providers are developing Action Plans and formal continuous quality improvement plans with measurable indicators of progress. Starting activities include development of welcoming policies, screening and counting assessments, and stage matched treatment planning.
- Two workgroups will be formed that will include representation from community mental health centers directors and fiscal managers, the DMH, the DADA, HSC, and change agents to develop a billing infrastructure for services to individuals with co-occurring disorders, and scope of practice/core competency guidelines necessary for clinicians to provide co-occurring services.
- Identify language changes needed in State Administrative Rule to reflect integrated treatment.
- Engage more families and consumers as Change Agents
- Develop plans for supporting twelve step dual recovery meetings across the State of South Dakota.
- Continue to engage tribal entities as partners.

Clinical Management Team and community mental health services

The Clinical Management Team (CMT) includes representation from the Division of Mental Health, community mental health centers, and consumers/family members. The Adult Sub-Committee of the CMT is focusing on improving mental health services for adults struggling with mental health issues. In transformation to recovery-oriented services, the CMT is using the ten fundamental components of recovery as the guiding force. These ten components are:

- Self-Direction
- Individualized and Person-Centered
- Empowerment
- Holistic
- Non-Linear
- Strengths-based
- Peer Support
- Respect
- Responsibility
- Hope

The ultimate goal of the CMT Adult Sub-committee is to create a system where services are recovery-oriented, and allow individuals to re-establish normal roles in the community, develop personal support networks, and increase their quality of life. This process includes the further refinement of a continuous quality improvement process that focuses on the implementation of an integrated system of care, which includes services to individuals with co-occurring disorders. Included in this process is the development and implementation of point-in-time measurements of such performance indicators as criminal justice involvement, stability in housing, employment, improved functioning, and social connectedness.

The Division of Mental Health also continues to work closely with the Clinical Management Team Children's Sub-Committee on plans and priorities set forth by the Children's System of Care Steering Committee for implementation of systems of care. The Clinical Management Team has established core competencies of systems of care, were involved in the original trainings on systems of care, and are included in training and development activities of the System of Care Pilot Project at Behavior Management Systems. They are now assessing additional needs and priorities for future trainings. Other activities include development of outcome measures such as increased school attendance, decrease in out of home placements, decrease in criminal justice involvement decrease in alcohol and drug use, and increase in child/family satisfaction with mental health services and supports. These important indicators will assist in assessing the system as a whole and the effectiveness of systems of care.

Accreditation Process

With transformation efforts focused on recovery, building systems of care, and integrated treatment for individuals with co-occurring disorders, the CMT and the Division of Mental Health enhanced the Accreditation Review Process of community mental health centers. The Accreditation Review includes an increased emphasis on individualized plans of care, recovery, consumer/family driven services, and strength-based person-

centered treatment provided in an integrated system of care, including services for individuals with co-occurring disorders. Components of the Accreditation Process include:

- Life quality interviews with consumers/families and "shadowing" of sessions.
- Chart reviews consisting of random chart pulls as well as quality service delivery by the centers.
- Involvement of community mental health center staff as reviewers. These individuals are direct service clinicians from other community mental health centers, who assist with chart reviews, life quality interviews, and shadowing of sessions. They are also available to consult on challenging cases.
- Exit interview that includes collaborative discussions with the mental health center staff in identifying strengths and challenges of service provision, and where improvements or changes can be made. This time has been extremely beneficial to both mental health providers and the Division of Mental Health, as it has allowed us to further partner together in transforming the mental health system.

Over the next few years, the Accreditation Process will continue to improve through additional emphasis placed on whether individuals and families co-occurring needs are being identified and addressed. Additional changes that will be reflected over the next three years include the addition of consumers and/or family members to the accreditation review teams, and plans to involve consumers/family members in the training of providers on recovery and systems of care, including what outcomes are meaningful.

Creation of an Adult Consumer Advocacy Group

In spring 2008, a group of consumers organized in a meeting sponsored by the National Empowerment Center (NEC) to begin development of a Consumer Advocacy Organization. The Division of Mental Health funded stipends for 45 consumers to meet for two days and attend an NEC sponsored training titled, "Finding Your Own Voice." Dr. Dan Fisher and Ms. Debbie Whittle from the NEC provided encouragement and guidance to consumers in building that voice and creating an advocacy organization. Consumers came away from the training with a name for the organization, South Dakota United for Hope and Recovery (SDUnited, for short), and the powerful vision statement, "*We are working together with dignity and respect as able human beings, to recover an equal place as full citizens in society, setting an example for others of empowerment and hope.*" In addition, the group formed a planning committee to create and develop plans to move forward with advocacy efforts. This planning group meets monthly and is now working on creating formal processes for implementation of a statewide Consumer Advocacy Group. The Division of Mental Health, the Council of Mental Health Centers, and community mental health center staff are closely allied with SDUnited to continue growth of consumer involvement and advocacy efforts, so that our state can further recovery-oriented services and consumer driven care.

Creation of a Family-Based Consumer Advocacy Organization

Technical assistance provided by Barbara Huff, former Director of the Federation for Families, has been utilized to promote the establishment of a family run advocacy organization centered on meeting the needs of children and youth with emotional, behavioral and mental health challenges and their families. Barbara Huff has assisted in networking families, providing them with ongoing training and assistance in advocacy efforts, and supporting them in the process of forming an organization that meets their needs in improving services for their children. In addition, key leaders in family advocacy within the state of South Dakota have focused their family advocacy efforts towards the System of Care Pilot Project Site at Behavior Management Systems. Issues are being identified in such a way that families are being linked and their individual as well as collective desires for involvement in organizational development are being supported. With the growth of family involvement within the SoC Pilot Project, the family voice, as it pertains to a state-wide family advocacy organization, is further disseminating information and resources to families across the state, as progress is made. Assistance to support family advocacy efforts within the Pilot Project has been and will continue to be provided by key leaders in family advocacy within the state of South Dakota.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	24.90	25	25.90	26.60	0	0
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Ensure all individuals statewide have access to appropriate, quality, recovery-oriented mental health services.

Target: Increase number of adults with severe and persistent mental illness served in the community mental health system.

Population: Adults with severe and persistent mental illness

Criterion: 2:Mental Health System Data Epidemiology
3:Children"s Services

Indicator: Percentage of adults with SPMI served.

Measure: Numerator: Numbers of adults with SPMI served with state funding.
Denominator: Estimated number of adults with SPMI.

Sources of Information: DMH Information System, WICHE Estimation of MH Need, WICHE Mental Health Program http://psy.utmb.edu.

Special Issues: The FY09 target for the number of adults with SPMI includes additional adults who will be served through an expansion of funding received to alleviate waiting lists. The FY10 target includes the number of adults estimated to be served through the FY10 budget request for expansion funds. Expansion amounts for FY10 and FY11 are unavailable at this time. The Division will update this number in the implementation report due December 2008.

The DMH relies on a data collection system (STARS) to provide client information and process billing. State totals provide unduplicated counts of individuals served statewide. STARS is interfaced with the Department of Social Services' Medicaid Management Information System(MMIS) which has expansive capabilities specific to Medicaid eligible consumers. The DMH and the Department of Social Services work closely to ensure the two systems are compatible and HIPAA compliant.

Prevalence data from WICHE was used rather than the information provided in the Federal Register. WICHE's data provided prevalence estimates broken out by severe and persistent mental illness, rather than only severe mental illness. Breakouts were also by county, based on the demographics of each county. This breakdown provides more accurate prevalence rates for South Dakota.

The WICHE data was computed based on census information from 2000. This data assumes the growth in the number of adults with SPMI is at the same rate as the total population.

Significance: Assuring access to mental health services for individuals suffering from a severe and persistent mental illness is a priority of the Division of Mental Health and the mental health block grant legislation.

Action Plan: The Division of Mental Health will continue to explore opportunities for additional funding for services to adults with severe and persistent mental illness.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	7.27	11.47	9	8	7	6
Numerator	131	193	--	--	--	--
Denominator	1,803	1,683	--	--	--	--

Table Descriptors:

Goal: Provide a comprehensive organized community based system of mental health care for adults with SPMI to include access to an array of appropriate services and resources.

Target: Reduction in percentage of admission rates to State Psychiatric Hospital within 30 days.

Population: Adults with severe and persistent mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Decreased rate of 30 day readmissions to the state psychiatric hospital(HSC)

Measure: Numerator: Number of persons, aged 18+, who are readmitted to HSC within 30 days

Denominator: Number of persons, aged 18+, who are discharged from HSC during the past year

Sources of Information: HSC Information Systems

Special Issues: The number of re-admissions is comprised of a duplicate count (i.e., an adult readmitted repeatedly would be counted at each readmission.)

The Division of Mental Health will continue to look towards opportunities for increasing funding and staff of community mental health centers to assist in reducing the number of hospitalizations of individuals with SPMI.

Significance: Reducing the utilization of state psychiatric inpatient beds will be a reflection on implementation of recovery oriented services within the community based system.

Action Plan: The Division of Mental Health, the Human Services Center, and representatives from the Council of Mental Health Centers participate in a Discharge Planning workgroup to streamline discharge planning to ensure that all individuals, once discharged from the hospital, are aware of and have immediate access to mental health services in the community. Currently, this group is developing a standard process of information sharing between community mental health centers and the Human Services Center upon admission and discharge. Improvements in discharge planning will be reflected in community mental health services as recovery oriented services continue to be implemented. In addition, a better process of assisting individuals with obtaining medications upon discharge will continue through the Indigent Medication Program.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	14.86	22.40	21	20	19	18
Numerator	268	377	--	--	--	--
Denominator	1,803	1,683	--	--	--	--

Table Descriptors:

Goal: Provide a comprehensive, organized community-based system of mental health care for adults with SPMI to include access to an array of appropriate services and resources.

Target: Reduction in percentage of admission rates to State Psychiatric Hospital within 180 days

Population: Adults with severe and persistent mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Decreased rate of readmissions to State Psychiatric Hospitals within 180 days

Measure: Numerator: Number of persons, aged 18+, who are readmitted to HSC within 180 days.
Denominator: Number of person, aged 18+, discharged from HSC during the past year.

Sources of Information: HSC Information System

Special Issues: The number of re-admissions is comprised of a duplicate count (i.e., an adult readmitted repeatedly would be counted at each readmission.)

The Division of Mental Health will continue to look towards opportunities for increasing funding and staff of community mental health centers to assist in reducing the number of hospitalizations of individuals with SPMI.

Significance: Reducing the utilization of state psychiatric inpatient beds will be a reflection on implementation of recovery oriented services within the community based system.

Action Plan: The Division of Mental Health, the Human Services Center, and representatives from the Council of Mental Health Centers participate in a Discharge Planning workgroup to streamline discharge planning to ensure that all individuals, once discharged from the hospital, are aware of and have immediate access to mental health services in the community. To date, this group has developed a standard process of information sharing between community mental health centers and the Human Services Center upon admission and discharge. Improvements in discharge planning will be reflected in community mental health services as recovery oriented services continue to be implemented. In addition, a better process of assisting individuals with obtaining medications upon discharge will continue through the Indigent Medication Program.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Supported Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Supported Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Assertive Community Treatment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	213	220	225	225	225
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Provide a comprehensive, organized community-based system of mental health care for adults with SPMI to include access to an array of appropriate services and resources.

Target: Increase the number of individuals receiving ACT by 5 individuals over the current level.

Population: Adults with severe and persistent mental illness.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Number of Individuals receiving ACT Services

Measure: Statewide total of individuals receiving ACT Services.

Sources of Information: DMH Information System

Special Issues: The Division of Mental Health, along with IMPACT Programs work together to identify individuals who require the intense services that IMPACT provides. These individuals have been unsuccessful in other community placements, and have had frequent psychiatric hospitalizations.

Significance: The Division of Mental Health believes that IMPACT is a very important service to offer to adult consumers who have been unsuccessful in less intensive services. Providing quality, recovery-oriented mental health services to individuals with severe and persistent mental illness is a priority of the DMH and the mental health block grant legislation.

Action Plan: Over the three year grant period, the Division of Mental Health and the IMPACT Programs will work closely together to assure there is a baseline fidelity to the evidence based ACT model through use of the SAMHSA ACT toolkit. During the last year, the Division of Mental Health and the IMPACT Programs developed forms to track data on client quality of life self reports, and quarterly client reports by IMPACT staff. Over the next three years, the Division will begin to analyze the data and work with the IMPACT Programs to refine performance indicators and data collection activities relative to recovery oriented services that are consumer driven and provided in an integrated system of care.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Family Psychoeducation (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders(MISA) (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	48	48	50	52	52
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Provide a comprehensive, organized community-based system of mental health care for adults with SPMI to include access to an array of appropriate services and resources.

Target: Increase the number of individuals receiving integrated treatment through Serenity Hills by 3 per year.

Population: Adults with severe and persistent mental illness.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Number of persons with SPMI receiving Serenity Hills Services.

Measure: Number of adults with SPMI, aged 18+, who are receiving services through Serenity Hills.

Sources of Information: DMH Information System

Special Issues: The Division of Mental Health and the Division of Alcohol and Drug Abuse have a cooperative agreement regarding Serenity Hills. Serenity Hills is a custodial care facility providing services to adults with a co-occurring disorder. Alcohol/Drug services and mental health services are integrated in a multidisciplinary model. The services are seamless, with a consistent approach and philosophy.

The Division of Mental Health plays an important role in development of co-occurring disorder services within the State. The Department of Human Services, which houses both the Division of Alcohol and Drug Abuse and the Division of Mental Health supports integrated treatment for individuals with co-occurring disorders.

Significance: Assuring access to mental health and chemical dependency services is of primary importance due to the increasing numbers of individuals diagnosed with co-occurring disorders.

Action Plan: Integration of mental health and substance abuse services for individuals with co-occurring disorders has been identified by the Mental Health Planning and Coordination Advisory Council and the Division of Mental Health as a priority area. South Dakota has convened key stakeholders including consumers, providers, higher education, advocacy groups, tribal representatives, state government officials and other interested parties that have agreed to adopt the Comprehensive, Continuous, Integrated System of Care (CCISC) model for designing statewide systems change to improve access and outcomes for individuals with CODD. Implementation of the CCISC model across the state will be an activity of all three years of the grant.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Illness Self-Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Medication Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	63.06	56.02	60	63	67	N/A
Numerator	227	149	--	--	--	--
Denominator	360	266	--	--	--	--

Table Descriptors:

Goal: Provide a comprehensive, organized community-based system of mental health care for adults with SPMI to include access to an array of appropriate services and resources.

Target: Increase in the number of people reporting positively about outcomes by 2% each year.

Population: Adults with severe and persistent mental illness.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Number of consumers reporting positively regarding outcomes

Measure: Numerator: Number of positive responses reported in the outcome domain on the adult consumer survey.
Denominator: Total responses reported in the outcome domain on the adult consumer survey.

Sources of Information: MHSIP Adult Consumer Surveys

Special Issues: This indicator demonstrates positive responses on outcomes for individuals receiving services within the public mental health system. The survey tool used was the 28-item MHSIP Survey. The survey is completed on an annual basis with individuals receiving services from the eleven community mental health centers. 8 questions are analyzed in determining positive reporting of outcomes by consumers. Individuals filling out the survey must check “strongly agree” or “agree" to the following statements:
• I deal more effectively with daily problems
• I am better able to control my life
• I am better able to deal with crisis
• I am getting along better with my family
• I do better in social situations
• I do better in school and/or work
• My symptoms are not bothering me as much
• My housing situation has improved

Significance: The Division of Mental Health recognizes the importance of positive outcomes for individuals receiving mental health services within the community mental health system. As the system transforms to a recovery oriented system, positive outcomes will become a very important indicator towards the quality of services.

Action Plan: The Division of Mental Health, community mental health centers, and the Advisory Council

recognize the importance of culturally competent, consumer-driven, strength-based, recovery-oriented treatment provided through an integrated system of care. Developing an individualized plan of care for every adult with a serious mental illness will assist in moving the system towards recovery and will allow consumers to actively participate in their own treatment and recovery, thereby increasing positive outcomes from services. The involvement of consumers and families in the move to orient the system towards recovery remains crucial, and the Division of Mental Health will continue to involve and support consumers in this system transformation. The Division of Mental Health will work closely with the Clinical Management Team in transformation activities. The Clinical Management Team (CMT) Adult Sub-Group membership includes individuals receiving mental health services as well as staff from each community mental health center and the Division of Mental Health. The subgroup will continue working on the development of performance indicators relative to recovery, positive outcomes, and individualized services. The feedback gathered from consumers is a critical piece in this process. The Division of Mental Health realizes this change involves long-term development plans and will be working on goals and objectives in this area over the next year of the grant and beyond.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Increase/Retained Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	0	20.35	25.14	27	29	31
Numerator	0	1,468	--	--	--	--
Denominator	N/A	7,215	--	--	--	--

Table Descriptors:

Goal: Provide a comprehensive, organized community-based system of mental health care for adults with SPMI to include access to an array of appropriate services and resources.

Target: Increase in the number of consumers who reporting they are working by 2% each year.

Population: All adults receiving mental health services within the community mental health system.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Percentage of adults receiving community mental health services that report they are working.

Measure: Numerator
Number of Persons Employed: Competitively Employed Full or Part Time

Denominator
[Employed: Competitively Employed Full or Part Time + Unemployed + Not In Labor Force: Retired, Sheltered Employment, Sheltered Workshops, Other (homemaker, student, volunteer, disabled, etc.)]

Sources of Information: Division of Mental Health management information system

Special Issues: This performance indicator includes all adults served within the community mental health system. This performance indicator is only collected at admission/discharge. This excludes persons whose employment status was “Not Available”. Data for FY05 and FY06 is not available, as the Division of Mental Health did not collect this data prior to FY07.

Significance: As the system moves towards recovery, the Division recognizes employment as being a very important positive outcome for adults receiving community mental health services.

Action Plan: Over the three years of the grant, the Division of Mental Health will be collaborating with the Division of Rehabilitation Services (DRS) to increase the employment opportunities available for individuals with severe and persistent mental illness. This collaboration will include examinations of current employment programs offered through community mental health centers, and how to expand these programs across the state. Together, the DMH and DRS will examine what services are provided, as well as positive outcomes directly related to services. In addition, the Division of Mental Health, as part of the Data Infrastructure Grant will be developing client level reporting capabilities for employment outcomes. This will give the Division a clearer picture of employment and positive outcomes for individuals receiving community mental health services, and allow us to change the performance indicator relative to employment.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	25	17.65	15	14	14	14
Numerator	5	3	--	--	--	--
Denominator	20	17	--	--	--	--

Table Descriptors:

Goal: Provide a comprehensive, organized community-based system of mental health care for adults with SPMI to include access to an array of appropriate services and resources.

Target: Decrease by 1% each year the number of consumers who report arrests in Yr 1 and re-arrests in Year 2.

Population: Adults with severe and persistent mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Percent of consumers arrested in Year 1 who were re-arrested in Year 2.

Measure: Numerator: Number of individuals reporting re-arrest during year Two
Denominator: Number of individuals reporting arrest during Year One

Sources of Information: MHSIP Adult Consumer Survey

Special Issues: This was not a measure in FY05, therefore data is not available.

MHSIP Surveys are conducted on an annual basis. A random sample of individuals that have received services during 3 months prior to dissemination of surveys are chosen. WICHE conducts the data analysis and completes the reports for the Division of Mental Health.

Significance: The Division of Mental Health recognizes that many individuals receiving community mental health services have been or are currently involved with the criminal justice system. It is a priority of the Division of Mental Health to decrease the contact with the criminal justice system that consumers receiving mental health services are experiencing.

Action Plan: The Division, the Advisory Council, and the community mental health centers are working together to develop performance indicators relative to criminal justice involvement. As system transformation to recovery oriented, individualized, strength based services occurs, we will work together to develop plans for decreasing of criminal justice involvement. Processes will include consumer/family involvement as much as possible, including involvement by the Adult Sub-group of the Clinical Management Team.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	.77	1.14	1	.90	.80	.70
Numerator	51	82	--	--	--	--
Denominator	6,635	7,183	--	--	--	--

Table Descriptors:

Goal: Provide a comprehensive, organized community-based system of mental health care for adults with SPMI to include access to an array of appropriate services and resources.

Target: Decrease percentage of consumers reporting homelessness or living in shelter.

Population: Adults receiving services in the community mental health system.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Percentage of consumers homeless or in shelters.

Measure: Numerator
Number of Persons Homeless

Denominator
From URS Table, all persons with living situation excluding (-) persons with Living Situation Not Available

Sources of Information: DMH information system

Special Issues: This performance indicator is only collected at admission/discharge.

Significance: Stability in housing is an important performance indicator to assist the Division of Mental Health in the transformation of community mental health to a more recovery-oriented system.

Action Plan: Over the next three years, the Division of Mental Health and the community mental health providers, with assistance from the DIG grant, will be developing client level performance indicators around living arrangements and stability in housing. This client level data will be reported at various points in time during service delivery. Having this additional data will have a positive impact on policy planning and processes as the community system is transforming to a more recovery oriented system.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	73.10	63.94	65	67	70	72
Numerator	231	172	--	--	--	--
Denominator	316	269	--	--	--	--

Table Descriptors:

Goal: Provide a comprehensive, organized community-based system of mental health care for adults with SPMI to include access to an array of appropriate services and resources.

Target: Increase number of adults in the community mental health system reporting increases in social supports and/or social connectedness by 2% each year.

Population: Adults with severe and persistent mental illness.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Percentage of individuals reporting increased social connectedness/social supports

Measure: Numerator: Number of individuals responding positively to questions related to social connectedness/social supports
Denominator: Total number of individuals responding to social connectedness/social support questions

Sources of Information: MHSIP Adult Consumer Surveys

Special Issues: This indicator demonstrates positive responses on outcomes for individuals receiving services within the public mental health system. The survey tool used was the 28-item MHSIP Survey. The survey is completed on an annual basis with individuals receiving services from the eleven community mental health centers. 4 questions are analyzed in determining positive reporting of social supports/social connectedness by consumers. Individuals filling out the survey must check “strongly agree” or “agree" to the following statements:
• I am happy with the friendships I have
• I have people with whom I can do enjoyable things
• I feel I belong in my community
• In a crisis, I would have the support I need from my family or friends.

Significance: The Division recognizes the importance of social supports/social connectedness for individuals receiving mental health services within the community mental health system. As the system transforms to a recovery oriented system, social connectedness is a very important indicator towards the quality of services.

Action Plan: The Division of Mental Health works closely with the Clinical Management Team Adult Sub-Group to build a system that is responsive to consumer needs and wants. In the process of transforming the mental health system, social supports/social connectedness is a crucial piece in treatment planning and service delivery. The Division will be continuing to refine the accreditation process, as well as provide trainings/education to providers/consumers/families on the importance of a recovery oriented, strength-based, outcome driven community mental health system.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	62.15	60.74	62	64	68	70
Numerator	197	164	--	--	--	--
Denominator	317	270	--	--	--	--

Table Descriptors:

Goal: Provide a comprehensive, organized community-based system of mental health care for adults with SPMI to include access to an array of appropriate services and resources.

Target: Increase in the number of individuals reporting increased levels of functioning by 2%.

Population: Adults with severe and persistent mental illness.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services
4:Targeted Services to Rural and Homeless Populations

Indicator: Percentage of consumers receiving CMHC services who report increased levels of functioning

Measure: Numerator: Number of individuals responding positively to questions related to level of functioning
Denominator: Total number of individuals responding to level of functioning questions

Sources of Information: MHSIP Adult Consumer Surveys

Special Issues: This indicator demonstrates positive responses on outcomes related to level of functioning for individuals receiving services within the public mental health system. The survey tool used was the 28-item MHSIP Survey. The survey is completed on an annual basis with individuals receiving services from the eleven community mental health centers. 5 questions are analyzed in determining positive reporting of social supports/social connectedness by consumers. Individuals filling out the survey must check “strongly agree” or “agree" to the following statements:
• I do things that are more meaningful to me.
• I am better able to take care of my needs
• I am better able to handle things when they go wrong
• I am better able to do things that I want to do.
• My symptoms are not bothering me as much

Significance: The Division recognizes the importance of increased level of functioning for individuals receiving mental health services within the community mental health system. As the system transforms to a recovery oriented system, level of functioning is a very important indicator towards the quality of services.

Action Plan: The Division of Mental Health works closely with the Clinical Management Team Adult Sub-Group to build a system that is responsive to consumer needs and wants. In the process of transforming the mental health system, level of functioning is a crucial piece in treatment planning and service delivery. The Division will be continuing to refine the accreditation process, as well as provide trainings/education to providers/consumers/families on the importance of a recovery oriented, strength-based, outcome driven community mental health system.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adults receiving services in predominately frontier/rural areas

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	32.80	.37	.37	.38	.39	.40
Numerator	257	289	--	--	--	--
Denominator	783	783	--	--	--	--

Table Descriptors:

Goal: Provide comprehensive mental health services to homeless and rural populations of adults with SPMI.

Target: Increase access to services in rural states by 1% each year.

Population: Adults with severe and persistent mental illness

Criterion: 4:Targeted Services to Rural and Homeless Populations

Indicator: Number of adults receiving services in catchment areas that are predominately frontier.

Measure: Numerator: Numbers of adults with SPMI who receive services in the catchment areas of Three Rivers Mental Health Center and Southern Plains Behavioral Health Center.
Denominator: Estimated prevalence of adults with SPMI in the catchment areas of Three Rivers Mental Health Center and Southern Plains Behavioral Health Center.

Sources of Information: Numerator: DMH information system.
Denominator: Western States Resource Book: State Mental Health Authority Survey and Needs Assessment—WICHE Estimation Project (http://psy.utmb.edu/estimation/index_htm/South%20Dakota.htm)

Special Issues: Prevalence data estimates that the catchment areas of Three Rivers Mental Health Center has the lowest rate of CARE services provided. When considering causal factors, the demographics of each county within this catchment area provides insight into the combination of barriers to be overcome. Consider (1) population per square mile (2) percentage of Native Americans (3) percentage living under 100% of the federal poverty level.

TRMHC (1) (2) (3)
Corson 1.7 48.5% 42.5%
Dewey 2.4 66.6% 44.4%
Perkins 1.4 1.4% 15.2%
Ziebach 1.1 64.0% 51.1%

This data compares to Statewide averages of 9.2 persons per square mile, 8.3% Native American, and 15.9% under 100% of the federal poverty guidelines.

Shannon County also has a high concentration of Native Americans and a significant population living under 100% of the federal poverty level (respectively 94.7% and 63.1%). Shannon County falls into the Behavior Management Systems catchment area.

Significance: Behavior Management Systems, Three Rivers Mental Health Center and Southern Plains Behavioral Health Services provide services in the most rural areas of South Dakota. These agencies also serve three of four of the State's largest Indian Reservations. Assuring access to mental health services for adults with SPMI is a primary goal of the President's New Freedom Commission Report and the Division of Mental Health.

Action Plan: The Division of Mental Health will continue to work with Behavior Management Systems,

Southern Plains Behavioral Health Services and Three Rivers Mental Health Center in the provision of mental health services to individuals in their rural catchment areas. The Division will also continue to allow both Southern Plains and Three Rivers to bill a rural CARE rate that is 20% higher than the regular rate. In addition, the availability of telemedicine (which is reimburseable through Medicaid) has assisted both centers with the psychiatric shortage in those catchment areas. The Division will continue to explore options for both Southern Plains and Three Rivers to continue to improve access for individuals in their catchment areas.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Average amount of public funds expended on mental health services for adults with SPMI

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	2,824	2,575.42	2,722	2,750	0	0
Numerator	11,257,671	11,633,186	--	--	--	--
Denominator	4,034	4,517	--	--	--	--

Table Descriptors:

Goal: Ensure resources for services to adults with SPMI are allocated based on consumer need.

Target: Increase the amount of public funds expended per adult with SPMI in relation to inflationary increases.

Population: Adults with severe and persistent mental illness

Criterion: 5:Management Systems

Indicator: Average amount of public funds expended on mental health services for adults with SPMI.

Measure: Numerator: Total amount of direct service expenditure for adults with SPMI in SFY.
Denominator: Total number of adults with SPMI receiving services in SFY.

Sources of Information: DMH Information System

Special Issues: The Division of Mental Health cannot provide FY10 or FY11 budget information at this time. These budget requests have not gone through the necessary state channels to be finalized. As they are finalized, the Division of Mental Health will update to reflect changes.

Significance: Ensuring resources are allocated appropriately is a priority of the DMH

Action Plan: The Division of Mental Health will continue to work with the Advisory Council and community mental health centers to make certain public funds are continuing to be allocated according to consumer needs.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Number of individuals who are homeless, or at risk of homelessness, receiving PATH housing funds

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	23	18	20	20	20	20
Numerator	598	471	--	--	--	--
Denominator	2,603	2,603	--	--	--	--

Table Descriptors:

Goal: Provide comprehensive mental health services to homeless and rural populations of adults with SPMI.

Target: Maintain number of homeless individuals served through PATH.

Population: Adults with severe and persistent mental illness and children with SED and their families

Criterion: 4:Targeted Services to Rural and Homeless Populations

Indicator: Number of adults and children/families who are homeless, or at risk of homelessness, receiving PATH housing funds.

Measure: Numerator: Numbers adults with SPMI and children with SED and their families who are homeless, or at risk of homelessness, and who receive PATH funds. Denominator: Estimated number of homeless individuals statewide.

Sources of Information: PATH annual reports submitted by CMHCs, and the 1999 Quantitative Assessment of Estimated Number of Homeless Adults, Children and Youth in South Dakota.

Special Issues: The number of homeless individuals served includes individuals that were provided outreach or contact, but not necessarily enrolled in PATH Programs.

PATH final numbers are not due until December of each year. Therefore, FY07 and beyond are estimates based on final numbers served in FY06.

The Division of Mental Health does not foresee additional funding through PATH. Therefore, target percentages will remain the same through all three years of the grant.

Significance: Assuring that PATH resources are being provided appropriately and according to the needs of individuals in the target population is a primary goal of the mental health block grant law and a contingency of PATH funding.

Action Plan: The Division of Mental Health is working closely with PATH providers to ensure individuals are receiving services that are individualized, strength based, and provided with a recovery focus. The Division will also work with PATH providers to develop performance indicators and outcome measures that will assist PATH programs in providing the highest quality of services possible to individuals that are homeless or at risk of homelessness.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑☐

Name of Performance Indicator: Participation in Treatment Planning

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	65	64	66	68	71	72
Numerator	195	165	--	--	--	--
Denominator	302	256	--	--	--	--

Table Descriptors:

Goal: Provide a comprehensive, organized community-based system of mental health care for adults with SPMI to include access to an array of appropriate services and resources.

Target: Increase in the number of consumers who reporting they are participating in treatment planning by 2% each year.

Population: Adults with severe and persistent mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Percentage of consumers receiving CMHC services who report participation in treatment planning

Measure: Numerator: Number of consumers surveyed reporting positively regarding participation in treatment planning.
Denominator: Total number of consumers surveyed that answered participation in treatment planning question(s).

Sources of Information: MHSIP Adult Consumer Survery

Special Issues: This indicator demonstrates positive responses on outcomes related to participation in treatment planning for individuals receiving services within the public mental health system. The survey tool used was the 28-item MHSIP Survey. The survey is completed on an annual basis with individuals receiving services from the eleven community mental health centers. Consumers must have answered "agree" or "strongly agree" to the question "I, not staff, have decided my treatment goals."

Significance: Evidence of participation in treatment planning for individuals receiving mental health services within the community mental health system is one of the highest priorities of the Division. As the system transforms to a recovery oriented system, consumer/family driven treatment is a very important indicator towards the quality of services.

Action Plan: The Division of Mental Health works closely with the Clinical Management Team Adult Sub-Group to build a system that is responsive to consumer needs and wants. In the process of transforming the mental health system, participation in treatment planning is a crucial piece in service delivery. The Division will be continuing to refine the accreditation process to ensure consumer participation in treatment planning and CMHC development of an internal quality assurance process to encourage the improvement of a recovery oriented, strength-based, outcome driven community mental health system.

South Dakota

Child - Establishment of System of Care

Child - Provides for the establishment and implementation of
an organized community-based system of care for individuals with mental illness.

Establishment of System of Care

The Division of Mental Health, in partnership with the Mental Health Planning and Coordination Advisory Council, has the responsibility to establish a system of public mental health services to meet consumers' needs. Through purchase of service agreements with eleven non-profit community mental health centers, the Division of Mental Health provides mental health services to children identified as having serious emotional disorders (SED) and their families. The program that provides these mental health services is the Children's SED Program (see this Criterion, Available Services for a detailed description of the SED Program). The agreements with community mental health centers also include the provision of outpatient services to non-targeted populations. In addition, each community mental health center receives a monthly allocation of state general funds to support emergency services based on the population of their respective catchment areas.

The transformation process of the community mental health system for children with serious emotional disturbance and their families involves development of Systems of Care (SoC) with integration of services for co-occurring disorders and disabilities.

Included in these transformation services is responsiveness to individual needs/wants as well as cultural differences. The Division recognizes that these processes need to include state agencies, providers, clinicians, consumers, and families.

The Division recognizes that these transformation processes must reflect the following themes:

- Services are welcoming, consumer driven, and person and family centered
- Services are hopeful, empathic, culturally appropriate, integrated, continuous, and recovery-oriented
- System change efforts involve a partnership in quality improvement that welcomes, includes, and empowers all levels of the system, including consumers, families and other stakeholders, in the continuous quality improvement (CQI) change process, and includes MH, CD, and DD services in all aspects of the process

During the last year, the Mental Health Advisory Council received technical assistance (TA) on increasing involvement of the Council in improving and strengthening the community mental health system. This TA has empowered the Advisory Council to enhance their involvement in strategic planning and advocacy efforts for children and families receiving mental health services.

The Department of Human Services, which includes the Division of Mental Health, the Division of Alcohol and Drug Abuse, the Human Services Center (state inpatient psychiatric facility), have identified development of integrated treatment for all individuals diagnosed with co-occurring disorders as one of its highest priorities. Drs. Minkoff and Cline are providing consultation to the state as part of this initiative. All stakeholders involved agree on the importance of building a system for co-occurring disorders, and have committed resources to help improve services to individuals with co-

occurring disorders. Every community mental health center and alcohol/drug provider has received on-site technical assistance to develop integrated services for individuals with co-occurring disorders. In addition, every CMHC has completed a Co-morbid Program Audit Self Survey (COMPASS) to assess program competencies and assist in the implementation of the Comprehensive, Continuous, Integrated, System of Care (CCISC) Model. Technical assistance and on-site training on integrated treatment for co-occurring disorders is now focusing on agencies developing Action Plans to assist in implementation of integrated services throughout the community mental health system. Workgroups that include representation from Change Agents, the Division of Mental Health, and community mental health center fiscal staff and Executive Directors are working in the areas of Billing and Reimbursement Practices and Development of Core Competencies in the provision of integrated services. In addition trainings are planned that will provide technical assistance to providers in development of integrated longitudinal strength-based assessments (ILSA); provide additional information on SAMHSA Tip 42; and, development of screening and assessment tools for determining needs of individuals, including those with co-occurring disorders. These will continue over the next three years of the grant and beyond.

In addition, as part of implementation of the CCISC model, community mental health centers and alcohol/drug providers have been encouraged to assign Change Agents from each of their respective agencies to drive implementation of integrated services from the local levels. The role of Change Agents in their local programs includes provision of training and supervision on the principles of the CCISC model and program consultation to facilitate development and implementation of quality improvement action planning to establish and enhance dual diagnosis capability in the programs as a whole. All community mental health centers and alcohol/drug providers have assigned Change Agents. These individuals meet on a regular basis as a group to discuss integration of services, receive training on areas such as welcoming attitudes/policies, strength-based treatment, screening, and assessment. The Change agents are then able to take this information back to their centers to share with other staff members. See Table C: Description of Transformation Activities for more information on the CCISC model and Change Agents.

Aligned with the recommendations from the New Freedom Commission and the South Dakota Children's Mental Health Task Force, the Division of Mental Health strives to provide services to children, adolescents, and their families through an integrated, culturally appropriate system of care. Typically, youth served by a system of care have multiple issues and, therefore, interact with multiple service sectors. In recognizing this, a Children's System of Care Steering Committee was created. Representation on the Committee includes the Departments of Human Services (Division of Mental Health and the Division of Alcohol and Drug Abuse), Social Services, Corrections, and Education; and the Unified Judicial System. The Steering Committee is working to ensure a system of care is developed to cross service sectors and deconstruct barriers to holistic services so that services can be offered in the least restrictive settings possible. Integral to the success of these services are a partnership with parents, families, and surrogate families of children.

As part of this effort, in 2007, the Children's System of Care Steering Committee developed an RFP for implementation of a System of Care (SoC) Pilot Project. This Pilot Project targets children and adolescents who meet Intensive Case Management eligibility criteria (See Child Plan, Criterion One, Available Services for criteria). Behavior Management Systems in Rapid City was chosen as the SoC Pilot Project site. During the last year, activities have focused on education of systems of care development for Behavior Management Systems staff as well as all local child/family serving agencies, purchase of wrap-around service curriculum and training tapes, and strategic planning for implementation of systems of care. See Table C: Description of Transformation Activities for more information on the SoC Pilot Program.

In addition, the Yankton Sioux Tribe, in southeast South Dakota, has received a Federal System of Care Grant. The Yankton Sioux Tribe has shared information on what they are focusing on in their SoC project to assist the SoC Pilot Project at Behavior Management Systems. The Yankton Sioux Tribe has agreed to work with the Division of Mental Health and other stakeholders to promote systems of care and further development statewide.

The Division of Mental Health also continues to work closely with the Clinical Management Team on plans and priorities set forth by the Children's System of Care Steering Committee for implementation of systems of care. Efforts in this area include development of outcome measures such as increased school attendance, decrease in out of home placements, decrease in criminal justice involvement decrease in alcohol and drug use, and increase in child/family satisfaction with mental health services and supports. In addition, the CMT will be developing and tracking outcomes for suicide prevention activities. These important indicators will assist in assessing the effectiveness of systems of care.

South Dakota families have been working to establish a family run organization for the advocacy of children and youth with mental health issues, and their families. The DMH helped to partner families with such experts as Barbra Huff to provide information and technical assistance to parents/families assisting in development of an organization. Currently, a parent of a child with a serious emotional disorder is working parallel to Barbra Huff's activities to pull families together into an organized system of advocates for community based mental health services. While the formation of this important organization is in the early stages, its establishment, and leadership will help drive transformation in the State mental health system.

Throughout the year, the DMH and members of the Advisory Council are also participants on many task forces, workgroups, planning groups, and committees with representatives of other stakeholder groups. Participation provides opportunities for the DMH to obtain additional input from a larger pool of individuals and agencies on important issues to consider for improvement of the community-based mental health system, as well as provide an avenue for the DMH to influence other stakeholders to consider mental health services as an important component in all human service fields of

work. Some of the workgroups that the Division of Mental Health participates with include:

- **Healthy Children, Healthy Future-Coordinated School Health Workgroup-**This workgroup includes membership from the Division of Mental Health, the Division of Alcohol and Drug Abuse, the Department of Education, the Department of Health, and the Department of Social Services. Activities within the workgroup include coordinating programming of various agencies to assist in improving the health, education, and wellbeing of young people. The eight components included as a focus are health education; physical education; health services; nutrition services; counseling, psychological, and social services; healthy school environment; health promotion for staff; and, parental community involvement.
- **Children's Mental Health Awareness Initiative-** The Division of Mental Health participates in a workgroup with representation from Voices for Children, Office of Childcare Services, the Council of Mental Health Centers and community mental health center staff, pediatricians, hospitals, and family members. Activities in the Workgroup focus on increasing community understanding and resources for developing emotionally healthy children and early identification, intervention and treatment of mental illness.
- **Children's State Placement Committee-**This Committee includes representation from the Division Mental Health, the Division of Developmental Disabilities, the Department of Education, Office of Special Education, the Department of Social Services, the Department of Corrections, the Human Services Center, and the Developmental Center in Redfield. This committee approves all out of state placements for youth across the State that are in need of specialized services.
- **Interagency Council on Homelessness**- The Council is challenged with a variety of duties, including identifying and defining homeless issues, determining effective strategies for the prevention of homelessness in South Dakota, providing public education, and working with various advocacy, business, faith-based groups, and consumers regarding policy and program development. The Council consists of the Governor; Cabinet Secretaries from the Departments of Health, Human Services, Social Services, Corrections, Education, and Labor; The Adjutant General of Military and Veteran's Affairs; The Director of Tribal Government Relations; and the Executive Director of the South Dakota Housing Development Authority.
- **Housing for the Homeless Consortium-**Involved in the Consortium are private businesses, disability service organizations, local cities/towns, public housing authorities, landlords, formerly homeless individuals, housing developers, regional community action agencies and state agencies, which includes the Division of Mental Health. The Consortium meets quarterly to provide opportunities for networking with other providers across the state, problem solve difficult situations, share ideas about "what works," share resource information, and to gain knowledge of new funding opportunities.

In addition, the Consortium gives South Dakota a mechanism to apply for federal homeless assistance funds from the U.S. Department of Housing and Urban Development (HUD).

- **Statewide Suicide Prevention Workgroup-**This workgroup includes representation from the Division of Mental Health, Department of Social Services, and Department of Health, local providers of mental health services, the Council of Mental Health Centers, public educators, Indian Health Services, hospitals, and family members. This workgroup is focused on development and support of local/regional suicide task forces as they offer education, advocacy, and support to both individuals and family members of those at risk for suicide, those who have attempted suicide, and those who have lost someone to suicide.
- **Collaborative Circle of Care-**This workgroup includes representation from the Division of Mental Health, Division of Alcohol and Drug Abuse, Indian Health Services, Council of Mental Health Centers, Alcohol/Drug Providers, community mental health centers, Wakanyeja Pawicayapi, Department of Social Services, Catholic Social Services, Lutheran Social Services, Native American Spiritual Leaders, and private child/family serving agencies. The Collaborative Circle of Care includes identified districts across the state that have formed regional collaboratives. Members of the Collaborative Circle of Care envision a system of child and family services and supports in South Dakota that ensures that each Native American child is safe and thriving in a permanent, appropriate home, that families receive support in their communities, and that communities themselves take responsibility for ensuring this vision becomes a reality. The Division of Mental Health participates on a sub-committee titled Services and Stability Committee, which prioritizes regular assessments of the service array in the districts, through the regional collaboratives, to assure the service array is adequate.

South Dakota

Child - Available Services

Child - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing
services;
Educational services;
Substance
abuse services;
Medical and dental services;
Support services;
Services provided by local school
systems under the Individuals with Disabilities Education Act;
Case management services;
Services
for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities
leading to reduction of hospitalization.

Available Services
The Division of Mental Health, the Mental Health Planning and Coordination Advisory Council, and the community mental health centers all collaborate to ensure the community based mental health system provides services that are comprehensive, culturally responsive, consumer driven, and provided with a recovery focus to all children and families with mental health issues, including those with co-occurring disorders. Although community mental health centers provide mental health services to all children/families identified with mental health issues, the highest priority target group is children with serious emotional disorders.

For purposes of receiving services through community mental health centers, identification of a child with serious emotional disorder (SED) is indicated by the following criteria:

- The individual is between 0 and 18 years of age or is between 18 and 21 years of age and needs a continuation of services that were started before the age of 18 in order to realize specific service goals or during transition to adult services; and
- The individual exhibits behavior resulting in functional impairment which substantially interferes with, or limits the individual's role or functioning in the community, school, family or peer group; and
- The individual has a mental disorder diagnosed under DSM III-R or DSM-IV (V Codes not included); and
- The individual demonstrates a need for one or more special care services, in addition to mental health services; and
- The individual has problems with a demonstrated or expected longevity of at least one (1) year or has an impairment of short duration and high severity

Community Mental Health Center Programs and Services
The eleven community mental health centers (CMHCs) that the Division of Mental Health contracts with have assigned catchment areas, broken out by county, for which they are responsible (See Attachment 3).

- All eleven CMHCs provide services through the Serious Emotional Disturbance (SED) Program
- All eleven CMHCs provide Intensive Family Services (IFS)
- All eleven CMHCs integrate services to children/youth with co-occurring disorders into SED program.
- Nine CMHCs provide intensive case management services.
- Seven of the eleven CMHCs are also core service agencies providing substance abuse services.
- Two of the eleven CMHCS provide therapeutic day treatment services for youth

<u>SED Program</u>
The children's SED program is an intensive and comprehensive, child-centered, family-focused, community-based, individualized integrated system of care which delivers mental health services to children with serious emotional disturbances and their families, including those with co-occurring issues (substance abuse, developmental disabilities).

The SED program provides access to a comprehensive array of services that address a child's physical, psychological, emotional, social, and educational needs, including assistance with issues related to using substances. The program provides children with individualized services in accordance with the unique needs and potentials of the child. These services are provided to children within the least restrictive, most normative environment that is clinically appropriate and in a manner that is sensitive and responsive to children's cultural differences and special needs. The parents, families, and surrogate families of children with SED are full participants in all aspects of the evaluation, planning, and delivery of SED services, which are integrated with all child-serving agencies and programs. The goal of these services is to ensure that children with SED are able to live with their families and in their home community, whenever possible.

Case Management.
Case management services assist children and families in gaining access to needed medical, social, educational, and other services. This includes referral and related activities to help children/families obtain needed services that are not provided through the community mental health centers. Monitoring and follow-up activities, including contacts that are necessary to ensure treatment plan goals regarding case management are effectively implemented and adequately address the needs of the child/family.

Vocational Coordination
SED Program staff also work together with the adolescent and family when the youth is seeking employment. Such services include assisting the individual in locating, securing and maintaining employment; or, assisting the individual in accessing services through other agencies or programs, such as Rehabilitation Services. An example of linking individuals to another agency would be through a program called "*Project Skills."* The State Vocational Rehabilitation Agencies, Division of Rehabilitation Services and Services to Blind and Visually Impaired fund this program to address the need for students with disabilities to get an opportunity to gain paid employment while in high school. Project Skills is a cooperative arrangement between the State VR agencies and the local school systems. The State VR agencies fund the wages, workers compensation, and FICA while the schools provide the job development, job coaching and follow-along for the student at the job site. This allows students with disabilities to take advantage of an important learning, maturing and socializing experience.

Educational Coordination
The community mental health center staff works in a variety of environments, including schools. Case managers are very involved in development of Individual Education Programs (IEPs). CMHC providers collaborate with families and school personnel to pool knowledge, experience, and commitment to design an IEP that will help the student progress in both the school and at home. See Criterion 3 System of Integrated Services for more information on educational services/linkages.

Medical/Dental Service Coordination
Children and families, especially those that are Medicaid eligible, have difficulty accessing oral health care. In 2006, only 32% of Medicaid children received any dental

services. According to the 2005 South Dakota Vital Statistics Report, twenty of the sixty-six counties (30%) in South Dakota do not have a dentist. In addition, only five Federally Qualified Health Care Centers in South Dakota provide dental services to South Dakota communities. To help address access to dental services, the Ronald McDonald House Charities of South Dakota, the Delta Dental Plan of South Dakota, the South Dakota McDonald's restaurant owners, and the South Dakota Department of Health collaborated to create the Ronald McDonald Care Mobile. The Care Mobile, a modern dental office on wheels, brings oral health services year-round to children from limited-income families who would not otherwise have access to much needed dentistry. The program started in September 2004 and as of August 2007, the program has provided over $2 million of dental care to more than 5,000 South Dakota Children.

According to the South Dakota Department of Health, Healthcare Workforce Center, over half (60%) of physicians in South Dakota currently practice or reside in urban communities of the state, while only 5.6% practice or reside in rural/frontier communities. There are over 50 Rural Health Clinics across the state; however, there are only six Federally Qualified Health Care Centers in South Dakota providing primary care services.

Due to the shortages of dentists and physicians, especially in the rural/frontier areas of the state, children and families face many challenges in receiving needed healthcare services. The SED program provides case management services that include holistic approaches to maintaining physical and mental health. SED staff work with individuals through regular referral/contact with agencies such as a child/family's primary health care physician and/or a dentist. SED case managers and family teams addresses the needs of children/families on an individual basis and referrals and linkage with other systems are contained within the treatment planning for that child/family.

Additional Services through SED.
Additional services offered through the SED program include:

- Individual Therapy
- Family Education/Support/Therapy
- Crisis Intervention
- Assessment and Evaluation
- Psychological Evaluation
- Group Therapy
- Parent/Guardian Group Therapy
- Liaison Services

Systems of Care
All community mental health centers have endorsed the development of local systems of care (SoC) in accordance with the generally accepted SoC guiding principles. These principles include: 1) The system of care should be child centered and family focused with the needs of the child and family dictating the types and mix of services provided; 2) The system of care should be community-based with the locus of services as well as management and decision making responsibility resting at the community level; 3) The

system of care should be culturally competent with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve; 4) The system of care should ensure that every child participates in an individualized plan of care that focuses on the needs, strengths, and challenges of the child and family; and 5) The system of care should ensure that interagency collaboration that engages all child- and family-serving agencies at all levels occurs (including child welfare, juvenile justice, mental health, education, substance abuse, health, etc.). As systems of care are developed, these principles are guiding the services provided through the SED program. See Table C: Description of Transformation Activities for information on Systems of Care development as part of the SED program.

Intensive Family Services

All eleven community mental health centers provide services through the Intensive Family Services (IFS) Program. This program is provided through collaboration between the Departments of Corrections (DOC) and Human Services, Division of Mental Health. IFS is a pre-aftercare program meant to provide an opportunity to families of youths who are placed under the jurisdiction of the Department of Corrections to address issues and access needed services to allow their children to return to their homes with the greatest opportunity for success. The Department of Corrections contacts the community mental health center (CMHC) to request a screening of the child's family to determine the level of services necessary for the family. IFS staff may provide basic case management services to the family through the DOC contract, or may forward the screening form to the Division of Mental Health for consideration for more intensive mental health services. The purposes of Intensive Family Services are:

- To assess the ability of the parent(s) and family to serve as an appropriate placement resource for the youth upon release;
- To assist families in dealing with issues that may have contributed to the out-of-home placements of the children.
- To promote the successful reintegration of the youth into their family upon their return or placement in the home upon release; and
- To reduce the likelihood of recidivism of the youth to the Correction system through improved family functioning.

Intensive Case Management Services

A crucial component in Systems of Care is intensive case management services. The Division of Mental Health was successful in receiving funding in FY06 and able to reallocate funds in FY07 to support targeted staff in six community mental health centers to provide intensive case management services to children and their families. In FY09, the Division was again successful in receiving funding for an additional three community mental health centers to support intensive case management services.

The target population for intensive case management is any child age 18 and under or between the ages of 18 and 21 who meets the eligibility criteria as outlined below. Children who meet these eligibility requirements are considered to be at-risk of out of home placement and in need of intensive services.

Intensive Case Management Eligibility Requirements:

1). Child with SED who meets one of the following:

- CPS involvement/referral
- Prior out-of-home placement/returning from out-of-home placement

2). Child with SED who meets at least two of the following:

- UJS (Unified Judicial System) referral
- DOC referral
- Child has co-occurring substance abuse issues or diagnosis
- Child has developmental or medical issues
- Involvement of multiple systems and parents unable to navigate them effectively
- Lack of community/family supports
- Parent with SPMI or history of mental health/psychiatric services
- Parent(s) unemployed or having financial difficulties
- History of abuse or neglect

3). Child who may not meet full criteria for SED but does meet the following criteria:

- Exhibits behavior resulting in functional impairment which substantially interferes with, or limits the individual's role or functioning in the community, school, family, or peer group --or--
- Has a mental disorder diagnosed under the DSM-IV-TR; and meets at least three of the following:
    - Has problems with a demonstrated or expected longevity of at least one year [without effective treatment] or has an impairment projected to be of short duration and high severity
    - Court involvement/probation
    - Commitment to Department of Corrections
    - Child has co-occurring substance abuse issues or diagnosis
    - Child has developmental or medical issues
    - Involvement of multiple systems and parents unable to navigate them effectively
    - Lack of community/family supports
    - Parent with SPMI or history of mental health/psychiatric services
    - Parent(s) unemployed or having financial difficulties
    - History of abuse or neglect

The Division of Mental Health continues to monitor outcomes of intensive case management looks to expand to the remaining two community mental health centers in the coming years

Therapeutic Day Treatment Services

Behavior Management Systems in Rapid City and Southeastern Behavioral HealthCare Services in Sioux Falls contract with private providers to offer therapeutic day treatment services, which enable children with SED to remain or return to the community by providing treatment services to children and their families. The treatment services provide a structured series of daily activities, and are designed to prevent movement to a

more intensive level of care, or are used as transitional services to step down from more intensive levels of care. Children served are engaged in therapeutic activities designed to develop and maintain a normalizing routine and provide an orderly schedule of activities to develop positive personal and interpersonal skills and behaviors. Participation in therapeutic day treatment services is driven by the needs of the child and family. All staff provide continuous encouragement to parents/guardians to participate in these services.

Residential Services

The Division of Mental Health does not currently fund residential services for children. The Department of Social Services, through the South Dakota Medical Assistance Program, provides coverage of treatment services in licensed group and residential treatment facilities for individuals who have behavioral or emotional problems requiring intensive professional assistance and therapy in a highly structured, self-contained environment. In some areas, community mental health centers contract with group and residential treatment facilities to provide services to youth with mental health needs residing in the facilities.

Transitional Services for Youth

According to Administrative Rule of South Dakota, community mental health centers must implement transition plans for youth receiving SED services when turning seventeen. These transition plans are integrated into the treatment plan. Community mental health centers collaborate with other child/family serving agencies to assist youth in transitioning to independent living. For example, for children that are in the foster care system, community mental health centers often collaborate with the Department of Social Services Independent Living Services Program. The Independent Living Services Program has Five Community Resource People (CRPs) located in regions across the state that are assigned catchment areas to cover the entire state. CRP's assist youth with setting up housing, employment, and education, banking and savings accounts, and linking to mental health and medical services. All youth in foster care can receive monetary incentives to assist them once living independently in the community. Different activities/accomplishments while in foster care qualify for funding the Starter Kit Incentive. Youth can earn up to $1,200 through the incentive program, and are eligible to receive this money even up to a year after being out of foster care.

Out of State Placement

The Division of Mental Health does not make out-of-state placements for children. However, the Division is included in the process for placing youth in out of state facilities through participation in the State Placement Committee. The State Placement Committee consists of representation from the following departments/divisions: Mental Health, Developmental Disabilities, Special Education, Social Services, Corrections, Human Services Center, and the Developmental Center. All activities are recorded and tracked by the Department of Social Services, Division of Auxiliary Placement. Out-of-state and in-state out-of-home placements are last resort options. The committee reviews each child/youth's information and discusses what level of care is most appropriate, including home-based community services. Out-of state placement requests must also include denials from in-state residential treatment facilities.

Discharge Planning between the State Psychiatric Facility and Community
The implementation of a comprehensive, organized, community-based system of services is a key strategy in reducing psychiatric hospitalizations within the state of South Dakota. The Division of Mental Health and the Human Services Center, the State psychiatric hospital are collaborating to build a seamless system of care as patients leave inpatient hospitalization and move to community-based services. A discharge planning workgroup comprised of individuals from the Division of Mental Health, the Human Services Center, and the community mental health center system was created to work on streamlining the discharge planning process to ensure that all individuals, once discharged from the State hospital, are aware of and have immediate access to mental health services in the community. Currently, the group is developing a standard process of information sharing between community mental health centers and the Human Services Center upon admission and discharge. In addition, a better process of assisting individuals with obtaining medications upon discharge has been implemented. This group will continue to meet to address any further areas of concern regarding discharge planning.

Discharge Planning from Juvenile Corrections Placement
The Division of Mental Health, in cooperation with the Division of Alcohol and Drug Abuse and the Department of Juvenile Corrections, continue to conduct joint intake screenings and assessments with youth entering STAR Academy, a Department of Corrections youth treatment facility. This process allows better identification of youth with co-occurring mental health and substance use issues upon their arrival on campus. Once identified, the goal is to provide specific services to the youth in a manner that best addresses the co-occurring issues. In addition to the intake process, the Division of Mental Health and the Division of Alcohol and Drug Abuse have developed a joint transition/discharge process that will set youth up with services in their home community prior to discharge from STAR Academy.

South Dakota

Child - Estimate of Prevalence

Child - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

Estimate of Prevalence

The Division of Mental Health serves two primary target populations-adults and children. The target population for the children system is children (age 0-21, if appropriate) with serious emotional disorders (SED). The definition of SED can be found in the Child Plan, Criterion 1: Available Services.

Based on the WICHE MH Estimation Project, estimates of need for mental health services for South Dakota children and youth with serious emotional disturbance are projected at 15,453 or 6.7% of South Dakota's population (Based on 2006 Census Data of 229, 836 individuals under the age of 21). In FY08, the Division of Mental Health provided services to 4,930 children with SED. Penetration rates based on prevalence estimates is 32%.

Not all of the estimated 15,453 children with SED and families receive services through the public mental health system. Due to the rural/frontier nature of the state, some individuals choose to seek services from primary care physicians. In addition, some individuals seeking community-based mental health services pay for these services from private sources (insurance, etc.). The actual number of individuals needing services from the community based mental health system is not known. The Division of Mental Health is continually working to improve access to mental health care in our state, and is forging key partnerships with primary care and private providers to explore issues related to estimate of need, prevalence, and penetration rates.

South Dakota

Child - Quantitative Targets

Child - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

Quantitative Targets
During FY08, the Division of Mental Health provided services to 4,727 adults identified as having severe and persistent mental illness. This total is an increase of 471 individuals over the FY07 total of 4,256. As there has been no new funding for the community mental health system, with the exception of additional funds to address waiting lists, the Division of Mental Health is setting targets for FY09-11 to approximately 1-1.5% higher than FY08. During FY09, it is estimated the Division of Mental Health will provide services to approximately 4,900 individuals with severe and persistent mental illness.

See Adult Plan: Section III: Goals, Targets, and Action Plans for goals and targets to increase access to services for adults with severe and persistent mental illness.

South Dakota

Child - System of Integrated Services

Child - Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:

Social services;
Educational services, including services provided under the Individuals with Disabilities Education Act;
Juvenile justice services;
Substance abuse services; and

Health and mental health services.

System of Integrated Services

Aligned with the recommendations from the New Freedom Commission and the South Dakota Children's Mental Health Task Force, the Division of Mental Health strives to provide services to children, adolescents, and their families through an integrated, culturally appropriate system of care. All eleven community mental health centers have endorsed systems of care guiding principles, which include:
1) The system of care is child centered and family focused with the needs of the child and family dictating the types and mix of services provided;
2) The system of care is community-based with the locus of services as well as management and decision-making responsibility resting at the community level;
3) The system of care is culturally competent with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve;
4) The system of care ensures that every child and family participates in an individualized plan of care that focuses on the needs, strengths, and challenges of the child and family; and,
5) The system of care ensures interagency collaboration that engages all child- and family-serving agencies at all levels occurs (including child welfare, juvenile justice, mental health, education, substance abuse, health).

The development of Systems of Care began with an intensive case management component. The target population for intensive case management is any child age 18 and under who meets the eligibility criteria. Children who meet these eligibility requirements are considered to be at-risk of out of home placement and in need of intensive services. The Division of Mental Health was successful in receiving funding in FY06 to support targeted staff in 3 community mental health centers to provide intensive case management services to children and their families. In addition, the Division reallocated funds for FY07 to support target ICM services at three additional centers. The Division was again successful in FY09 to receive funding for an additional three centers for intensive case management. The Division of Mental Health continues to monitor outcomes of intensive case management and will look to expand this component to the final two community mental health centers in the next few years.

The Division of Mental Health and the Clinical Management Team also recognized that children/youth served have multiple issues and, therefore, interact with multiple service sectors. In recognizing this, a Children's System of Care Steering Committee was formed. The Steering Committee works to ensure a system of care is developed across service sectors to provide holistic services in the least restrictive settings possible. Representation includes the Departments of Human Services, Social Services, Corrections, and Education; the Unified Judicial System; and the community mental health centers. The System of Care Steering Committee is now focusing on the implementation of systems of care through the System of Care Pilot Program at Behavior Management Systems. Integral to the success of systems of care development is the partnership with parents, families, and surrogate families of children. See Table C: Description of Transformation Activities for more information on the System of Care Pilot Project.

In addition, as part of transformation activities, the Division of Mental Health and community mental health centers are focused on ensuring the needs of individuals with co-occurring disorders are met. To this end, the Division of Mental Health, the Division of Alcohol and Drug Abuse, the Human Services Center, community mental health centers, and alcohol and drug providers are all committed to ensuring systems of care development includes integrated treatment for children/families with co-occurring issues and needs. See Table C: Description of Transformation Activities for additional information on implementation of integrated treatment.

The Division of Mental Health, through the Children's Serious Emotional Disturbance (SED) Program, promotes the provision of mental health services in a community setting with hospitalization or other out-of-home placement being the choice of last resort. SED services include case management services to assist the child and family with the identification of strengths and needs to create a strength-based, outcome-focused case service plan. Services are provided using a team approach involving the child; family; other service providers such as social services, education, corrections; and any other parties that may be involved with the family including persons chosen by the family such as friends, family members, advocates, etc. Assistance with accessing other community resources or other resources within the community mental health center, such as substance abuse counseling, is accomplished under the broad spectrum of children's services.

As part of case management duties, community mental health center staff also assists adolescents in locating, securing and maintaining employment or assisting the individual in accessing services through other agencies or programs. See Child Plan, Criterion One, Available Services for more information regarding employment services.

Due to the shortages of dentists and physicians, especially in the rural/frontier areas of the state, children and families face many challenges in receiving needed healthcare services. As mentioned under Child Plan, Criterion One, the Ronald McDonald Care Mobile provides oral health services year-round to children from limited income families who would not otherwise have access to much needed dentistry. This availability assists SED staff in supporting the medical/dental needs of children and families. The SED program provides case management services that include holistic approaches to maintaining physical and mental health. SED staff work with individuals through regular referral/contact with agencies such as a child/family's primary health care physician and/or a dentist. SED case managers and family teams addresses the needs of children/families on an individual basis and referrals and linkage with other systems are contained within the treatment planning for that child/family.

Community mental health centers work very closely with school personnel in identification and early intervention for children identified through IDEA as having a serious emotional disturbance. CMHC staff work with school counselors and teachers to provide early interventions and in the development of systems of care for youth in their communities. They also work with youth, families and Individual Education Plan (IEP)

teams to not only ensure that needed mental health services are being provided, but also that the child is receiving appropriate education, despite mental health issues or other learning disabilities. Community mental health center staff is also involved in development of groups such as life skills and building self-esteem, and education for youth, teachers, and counselors regarding identification and interventions.

The Unified Judicial System (UJS), Child Protective Services (CPS), the Department of Corrections (DOC), and community mental health center directors continue collaborative efforts to improve the referral and service delivery system for children who are referred by UJS or CPS to a community mental health center. Memorandums of understanding (MOUs) are in place that address the following: 1) procedures for transacting standardized referrals for children's mental health services from the courts/CPS to respective community mental health centers; 2) practices for minimizing "no shows" among referred children/families; and 3) principles for assuring effective co-management of referred children and families. In addition, Child Protective Services (CPS) MOU includes the following: 1) the development of a uniform intake/referral process for mental health services; 2) the development of a uniform referral/follow-up process for child abuse assessments; 3) the adoption of principles for the co-management of referrals; and 4) the identification of service gaps. These MOU's are implemented on a local level between CPS/UJS offices and local community mental health centers.

The Division of Mental Health in cooperation with the Division of Alcohol and Drug Abuse and the Department of Juvenile Corrections conduct joint intake screenings and assessments with youth entering State Treatment and Rehabilitation (STAR) Academy, a DOC facility for juveniles. This process allows better identification of youth with co-occurring mental health and substance use issues upon their arrival on campus. Once identified, the goal is to provide specific services to the youth in a manner that best addresses the co-occurring issues. In addition to the intake process, the Division of Mental Health and the Division of Alcohol and Drug Abuse have developed a joint transition/discharge process that will set youth up with services in their home community prior to discharge from STAR Academy. See the Transformational Efforts and Activities section of this Criterion for more information on collaborative efforts relative to co-occurring disorders.

South Dakota

Child - Geographic Area Definition

Child - Establishes defined geographic area for the provision of the services of such system.

Geographic Area Definition

South Dakota's community-based mental health delivery system consists of eleven private, non-profit community mental health centers. Each mental health center is governed by a local board of directors and each center has a specific geographic service area for which it has responsibility. Please see Child Plan, Section I, Description of Regional Resources for information on the geographical service areas assigned to each community mental health center.

South Dakota

Child - Outreach to Homeless

Child - Describe State's outreach to and services for individuals who are homeless

Outreach to Homeless

Through the Projects for Assistance in Transition from Homelessness (PATH) Formula Grant Program (P.L. 101-645, Title V, Subtitle B), the Division of Mental Health makes funds available to accredited community mental health centers. The allocation amounts are based on the need for services. The more urban areas of Sioux Falls and Rapid City have the largest homeless populations; therefore, the need for funding to address the issue of homeless is greatest in these locations-and they receive the highest allocation amounts. The primary goal of PATH is the identification and provision of services to children with a serious emotional disorder and/or co-occurring substance abuse issue, and their families, who are homeless or at imminent risk of homelessness, and who have not previously been served or served successfully by community mental health centers. Children with serious emotional disorders (SED) who have a parent/guardian that meets the criteria for PATH eligibility would also be eligible for PATH funds.

As part of PATH services, the local PATH Outreach Workers work with the homeless families in identifying children and youth with SED who may be at risk of homelessness. The Outreach Workers would then assist the parent(s)/guardian(s) in securing needed mental health services for their children and link them with other services the child/family needs to remain in the community. In summary, the local PATH programs would provide assistance until the family becomes linked with ongoing mental health treatment and/or case management, and social service agencies, or when the family is no longer homeless, or no longer accepts services. In addition, if a child is already identified as SED and receiving services through the SED program, and the child and family become homeless, or have an increased risk to become homeless, the SED care coordinators will work with the families to locate and obtain permanent, stable housing, as well as link the child/family with other child serving agencies to assist in keeping the family intact and healthy.

In order to make the best use of PATH funds, the Division has divided funds into two separate categories. Category 1 is for the provision of direct mental health services. Category 2 funds are used for one-time rental assistance and security deposits. Category 1 funds are made available to provide the following services:

- Outreach services
- Screening and diagnostic treatment services
- Habilitation/rehabilitation services
- Community mental health services
- Case management
- Alcohol/drug treatment services
- Referrals for primary health services
- Job training
- Educational services

Many of the individuals eligible for services under PATH have not historically linked with the community mental health center system or have received limited services due to sporadic utilization. The ability to provide services in a variety of locations and to consumers who are not tied to a specific funding source should assist individuals in

accessing the necessary supports in a less intrusive, more comfortable fashion. An additional benefit is the flexibility for staff to monitor consumer status in a non-clinical setting.

See also the Adult Section III, Criterion 4, Outreach to Homeless for information on the Training for Trauma-Informed Care, Interagency Council on Homelessness, and the Housing for the Homeless Consortium.

South Dakota

Child - Rural Area Services

Child - Describes how community-based services will be provided to individuals in rural areas

Rural Area Services
South Dakota is predominantly a frontier State with 66 counties and 76,536 square miles. Nine Indian Nations are spread throughout the state and encompass 15,000 square miles. According to 2006 Census population estimates, the population for South Dakota is 781,919. Below is the breakdown of Race/Ethnicity across the State.

Race/Ethnicity	Percent of Population
Caucasian	88.4%
Native American	8.5%
African American	0.9%
Asian	0.7%
Native Hawaiian/Pacific Islander	0.05%
More than One Race	1.4%
Hispanic Ethnicity	2.0%

Thirty-four of the state's counties are classified as frontier (less than 6 persons per square mile) and thirty-one are classified as rural (6 to 99 persons per square mile). Minnehaha County in the southeastern part of the state is considered the only urban (100 or more persons per square mile). According to the South Dakota Department of Health, Office of Rural Health, sixty-one of the sixty-six counties in South Dakota are considered mental health professional shortage areas.

Children and families in rural areas receive services through the Serious Emotional Disorder (SED) Program, just as those in more urban areas. However, the barriers faced in mental health service provision in the rural areas of the state are numerous and difficult to overcome. Three Rivers Mental Health and Chemical Dependency Center, in the northwest portion of the state provides services to the counties of Corson, Dewey, Harding, Mead, Perkins, and Ziebach. This also includes areas of the Standing Rock and Cheyenne River Sioux Nations. Southern Plains Behavioral Health Services in the south central region of South Dakota covers the counties of Gregory, Mellette, Todd, and Tripp. The Rosebud Sioux Nation is also included in this area. The rural nature of each of these service areas poses some unique challenges in delivery of mental health services. To assist in addressing access to care issues such as lack of transportation and financial resources, community mental health centers (CMHCs) have established satellite offices in rural areas of their catchment areas and are committed to providing services in the person's home or community.

The Division of Mental Health implemented a rural rate for SED services that is 20% higher than the regular rate to help address higher expenses due to travel time and non-billable staff time when delivering mental health services. Community mental health centers are reimbursed at the rural rate for any services provided twenty miles from a main or satellite office. Because the entire catchment area of Southern Plains Behavioral Health Services and Three Rivers Mental Health Center are in the most rural areas of the state, these two centers are allowed to utilize the rural rate for all SED services provided throughout their respective catchment areas.

Psychiatry services in the rural and frontier areas of the state pose a significant challenge to providing a broad continuum of care. Often psychiatrists are not willing to live and work in these

rural and frontier areas, and contracting with those who are willing is very expensive for mental health providers. In working to develop a solution to the shortage of psychiatric services in rural areas, the Division was successful in lobbying the Office of Medical Services, Department of Social Services, to include telemedicine as a reimbursable service. Using broadband bi-directional video conferencing, psychiatrists can interact with patients at distant locations. Telemedicine has played an important role in improving access to mental health care in rural/frontier areas of the state.

South Dakota

Child - Resources for Providers

Child - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

Resources for Providers

Financial Resources

Targeted amounts in the FY09 budget specifically for children with serious emotional disturbances are $8,851,928. Funding includes Medicaid, block grant, and state general funds. Included in this budget are services provided through the SED program. The entire community-based budget is $22,456,183 and includes services to individuals with severe and persistent mental illness (SPMI), children with serious emotional disturbance (SED) as well as other services such as outpatient, emergency, protection and advocacy, and the Indigent Medication Program. Expenditure and utilization data is provided to the Mental Health Planning and Coordination Advisory Council at their quarterly meetings.

The State of South Dakota provides medical and mental health services to a large number of children eligible for Medicaid. The Department of Social Services' (DSS) budget includes a federally mandated State general fund match to federal Medicaid dollars to provide medical services to children that are Medicaid eligible. In an agreement established through a memorandum of understanding with DSS, the DMH budget includes a federally mandated State general fund match to federal Medicaid dollars to provide mental health services to children that are Medicaid eligible. Through funding provided by the State Children's Health Insurance Program (CHIP), South Dakota's Medicaid program has expanded to cover all children under 19 whose families' incomes are at or below 140% of the federal poverty level. In addition, CHIP-NM has been created to allow families, who are not eligible for Medicaid or CHIP and whose incomes are at or below 200% of federal poverty level, to qualify. Each community mental health center has made it a priority to educate families on the eligibility criteria and application process for CHIP, as well as the overall advantages to being involved in the program.

Children's SED services, which include psychiatric services provided by a psychiatrist or Certified Nurse Practioners/Physician Assistants are funded through a fee for service paid for every fifteen minute unit of service. One of the main priorities of the Division of Mental Health is to provide access to services in the most rural/frontier areas of the state. Despite no additional funding being allocated, the Division in was able to include a rural rate for services provided 20 miles from a main or satellite office. This rural rate, which is 20% higher than the standard SED rate, enhances access to funding for centers in rural and frontier areas with higher expenses due to travel time and non-billable staff time. Due to their entire catchment areas being in frontier areas of the state, Three Rivers Mental Health Center in Lemmon and Southern Plains Behavioral Health Services in Winner use the rural rate for all mental health services delivered to children with SED. Emergency services are also provided through purchase of services agreements with the eleven community mental health centers.

Current rates for services will be evaluated as part of an ongoing process. The Division of Mental Health will provide ongoing training addressing rate change issues, changes in current procedural terminology (CPT) codes, and making our systems compliant with HIPAA requirements.

The Division of Mental Health uses MIS data to monitor contract and Medicaid Expenditures. Expenditure and utilization data is then shared with the Mental Health Planning and Coordination Advisory Council during their quarterly meetings.

Services to Veterans

Due to the high incidence of mental disorders for veterans returning from Iraq, and the high number of National Guard Units in South Dakota, the Council of Mental Health Centers and the Division of Mental Health are collaborating with the South Dakota National Guard to provide mental health services to these veterans returning from Iraq and their families. Provision of these services has been very helpful to vets and their families, especially those living in the most rural/frontier areas of the state where access to mental health services is limited.

Management Information Systems

The Division of Mental Health and the Division of Alcohol and Drug Abuse share a management information system. The State Treatment Activity Reporting System (STARS) allows both Divisions the capacity to collect important data on the National Outcome Measures as well as on state specific performance indicators. Community mental health centers provide data for STARS either through direct entry, or batch loading from their information systems into STARS. STARS collects information on demographics of individuals served, as well as service utilization. Information collected in STARS is invaluable to the preparation of Block Grant goals and objectives as well as the Uniform Reporting System (URS) Tables.

Evaluation of Services

On an annual basis, the Division of Mental Health conducts Mental Health Statistic Improvement Program (MHSIP) Surveys with individuals receiving services through the community-based mental health system. Participants include adults with severe and persistent mental illness, youth (14-18) with serious emotional disorders, and families of children (0-18) with serious emotional disorders. The Western Interstate Commission for Higher Education (WICHE) pulls a random sample of individuals that have received a service within the three months prior to drawing the sample. The survey provides data on participation in developing the treatment plan, improved functioning, improved social connectedness, criminal justice involvement, culturally appropriate services provision, and overall satisfaction with the mental health services. WICHE compiles the data and provides a report back to South Dakota that is shared with the community mental health centers. This survey and evaluation is assisting in transformation of the community mental health system to be recovery-oriented and consumer driven.

Training opportunities

Qualified Mental Health Professional Training

To ensure the involuntary commitment process for children is being handled appropriately, the Division of Mental Health offers a Qualified Mental Health Professional (QMHP) Endorsement, which allows qualified individuals to perform the mental health status examination prior to the involuntary commitment of children.

Licensed Social Workers, Marriage and Family Therapists, Licensed Professional Counselors, Psychologists, and Psychiatric Nurses/Certified Nurse Practioners qualify to become endorsed as QMHPs. The availability of so many professions having the ability to be endorsed assists South Dakota in overcoming rural issues of the state when individuals are faced with involuntary commitment. The QMHP training includes information on the following:

- Involuntary Commitment Process
- Mental Health Status Examination
- South Dakota Laws relative to inpatient hospitalization
- Hearing Procedures for QMHP's in the commitment process of a child

Recovery and Peer Support Training

In FY08, The DMH consulted with the Depression and Bipolar Support Alliance (DBSA), in conjunction with the National Association of State Mental Health Program Directors (NASMHPD's) National Technical Assistance Center, and with support from SAMHSA's Center for Mental Health Services to sponsor a Transformation, Recovery, and Peer-Support Institute (TRPSI). This consumer-run institute took place in fall of 2007 as part of the annual South Dakota NAMI conference. South Dakota consumers, family members, and community mental health providers gathered to build plans together to make recovery real in South Dakota. Workshop sessions included training on:

- Building partnerships to cooperatively transform Mental Healthcare in South Dakota
- How Self-Help / Peer Support can be used to support the traditional mental health system
- What is Peer Support and how to make it a reality
- Advocacy Thru Self-Help / Peer Support
- Growing Your Grassroots Organization
- The Emerging Movement of Consumers as Providers
- Planning for Transformation in South Dakota
- Beyond Stabilization: Recovery-Orientation for Providers
- Creating a Statewide Recovery Network

Systems of Care and Integrated Treatment Training and Development

In June 2008, the System of Care (SoC) Pilot Project at Behavior Management Systems in Rapid City held a Search Conference. All community mental health centers, local/regional service agencies (Department of Corrections, Department of Social Services, Department of Education, and Unified Judicial System), and family members were invited to attend the conference to learn more about SoC development and implementation. Topics discussed at the conference included analysis of the human service system, the environment of the community, and integration of the system and environment through strategic planning and diffusion of the plan.

Another important component of systems of care is development of wrap-around services. Wraparound is a family centered, individualized way to reach out to families with complex, unmet needs. It is about meeting needs and producing results that reflect a family's culture, priorities, and values. As part of the SoC Pilot Project, Behavior

Management Systems has purchased an effective, reputable Wraparound Curriculum and videotape training. This particular curriculum was chosen after extensive research on behalf of WICHE. National SoC experts endorsed these training materials, including faculty at the University of South Florida, Mental Health Institute. Behavior Management Systems is starting to utilize this curriculum, but has not included the curriculum formally within the project activities. Next steps will include identification of needs and priorities relative to wrap-around services, the curriculum purchased, and development of a training plan and time for delivery.

Change Agents within community mental health centers and alcohol and drug providers are receiving training on Integrated Longitudinal Strength-Based Assessments (ILSA), treatment planning, screening and identification of individuals with co-occurring disorders, and how to build integrated care into the system. Strength-based, comprehensive assessments will aide providers in developing individualized plans of care for individuals with mental illness. Upcoming trainings over the next year will include a workshop on SAMHSA's Tip 42: Substance Abuse Treatment for Persons with Co-Occurring Disorders; additional lecture and demonstration on development of ILSA; and, formulation and treatment planning for individuals with co-occurring disorders.

Suicide Prevention and Intervention Training

As part of the State/Tribal Youth Suicide Prevention and Intervention Grant, community mental health center staff are participating in various trainings for suicide prevention and intervention. To date, over 1,000 individuals statewide have received training on suicide prevention and intervention. These individuals include community members, caregivers, mental health/alcohol drug providers, family members, school staff, law enforcement, child welfare staff, and university staff/students. Trainings have included:

- Applied Suicide Intervention Skills Training (ASIST). ASIST is a 2-day workshop designed to teach the skills to intervene with an individual at risk of suicide. Developed by LivingWorks Education, Inc., the workshop prepares gatekeepers to build a local "safety net" for those at risk.
- SafeTALK is a LivingWorks' program that trains community members to recognize persons with thoughts of suicide and connect them to suicide intervention resources.
- Working Together, a program developed by LivingWorks, is a one-day learning experience for community helpers/members. It is designed to help community members bridge gaps within their communities to increase support for persons at risk for suicide.
- Lifelines is a school-based suicide prevention curriculum. The topics of the lessons include attitudes about suicide, warning signs of suicide, school resources and role-playing exercises for students. The program also includes school-based model policies and procedures for responding to at-risk youth, suicide attempts, and completions; presentations for educators and parents; and a one-day workshop to train teachers to provide the curriculum. LifeLines is being taught to eighth and ninth graders at the 25 high schools identified as part of the Suicide Prevention and Intervention Grant.

The Division, in partnership with Sinte Gleska University and Wakanyeja Pawicayapi, Inc., is offering cultural awareness trainings to all mental health providers, community members, and caregivers, specifically on Lakota culture, history of trauma, and Lakota mental health and wellness beliefs. Thirty trainings over a three-year period are offered in different communities across the state. These trainings assist community mental health centers in incorporating cultural sensitivity into the services provided to youth and families. In addition to these trainings, the Division of Mental Health works with the Advisory Council and the community mental health centers to identify further needs in implementation of a culturally competent, integrated system of care.

Other areas of training

Other areas the Division of Mental Health and the community mental health centers are working together to provide clinician training:

- Rural Mental Health Grand Rounds Web casts through WICHE are available to all community mental health providers. Topics have included Rural Evidence Based Practices, Collaborative Health Care, Telemedicine, Screening and Intervention, and Developing Cultural Awareness and Culturally Competent Services.

South Dakota

Child - Emergency Service Provider Training

Child - Provides for training of providers of emergency health services regarding mental health;

Emergency Service Provider Training

Crisis Counseling

The Division of Mental Health, through Regular Services Program Grant closed out in summer 2007, provided assistance to individuals and families affected by flooding in the Northeastern region of the state. This Grant funded the "Caring Hands" crisis counseling team, which was located in Aberdeen, South Dakota. Caring Hands was a group of local individuals who spent their time conducting door-to-door outreach, community education groups on recovery from disasters, and working with area schools providing disaster education to children. The program was a very successful example of disaster response in a rural area, and considered a valuable learning tool to all involved.

In addition, due in large part to a 2006 Emergency Response Grant, South Dakota was able to build the emergency response capacity of mental health and alcohol/drug personnel, as well as hospitals, emergency medical technicians, and other first responders in communities. Trainings in the Critical Incident Stress Management (CISM) model and the development of South Dakotans ability to be CISM trainers has allowed the state to continue these efforts over the last few years. The Division continues to work with the Office of Emergency Management and other state agencies to ensure first responders are able to respond appropriately to mental health emergencies.

Local Provider Trainings

Community mental health centers provide numerous trainings for emergency service providers on local levels. Below is a list of community mental health centers and trainings that are provided:

- Community Counseling Services (CCS) in Huron conducted a four-hour training for the Huron Police Department on law enforcement interventions with individuals with serious mental health issues. CCS staff also conducted trainings and provided services to the police department and the ER staff of the local hospitals on critical incident debriefing.
- Dakota Counseling Institute (DCI) in Mitchell provides an annual training to law enforcement officers on mental health issues in general with specific emphasis on suicide and involuntary versus voluntary commitments. In addition, DCI staff began last year to provide trainings to juvenile jail staff specific to youth mental health issues. DCI staff also conducted a daylong training on bullying for the school system in Chamberlain.
- The Human Service Agency (HSA) in Watertown conducts six trainings/year on interacting with people with mental illness to the Watertown Police Department. All police personnel were required to attend. In addition, the Executive Director of HSA conducts a two-hour in-service on stress management to the Watertown Fire Department on an annual basis.
- The Executive Director of Lewis and Clark Behavioral Health Services (LCBHS) in Yankton is the Clinical Director for the Missouri valley Critical Incident Stress Management Team (CISM). The CISM team participates in quarterly meetings with emergency medical staff (EMS) and law enforcement to train on mental health related issues. In addition, LCBHS staff conducts training for the local

police and the sheriff's office on an annual basis. LCBHS also hosts an annual Mental Health Awareness Conference that offers sessions on mental health and law enforcement issues.

- Northeastern Mental Health Center (NEMHC) clinicians provided training on sex offender issues and adolescent development to juvenile corrections staff training In addition, NEMHC provided an in-service on Autism to two head start programs and one daycare in the Aberdeen area. Northeastern staff also presented a workshop on the Stigma of Mental Illness to consumers, human service providers, and family members.
- Southeastern Behavioral HealthCare (SEBHC) in Sioux Falls has provided trainings to local law enforcement and jail personnel on mental health issues, and detecting and preventing suicides of individuals within the jail system.

South Dakota

Child - Grant Expenditure Manner

Child - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

Grant Expenditure Manner

Through purchase of service agreements with eleven non-profit Community Mental Health Centers, the Division of Mental Health provides services to individuals. The Block Grant funds will be allocated to services for children with serious emotional disturbances (SED) receiving services through the SED Program.

The Children's SED Program is an intensive and comprehensive, child-centered, family-focused, community-based, individualized, integrated system of care, which delivers mental health services to children with a serious emotional disturbance, including those with co-occurring issues. The SED program provides access to a comprehensive array of services that address a child's physical, psychological, emotional, social, and educational needs. The SED program provides children with individualized services in accordance with the unique needs and potentials of each child. These services are provided to children within the least restrictive, most normative environment that is clinically appropriate and in a manner that is sensitive and responsive to children's cultural differences. The parents, families, and surrogate families of children with SED are full participants in all aspects of the evaluation, planning, and delivery of SED services, which are integrated with all involved child-serving agencies and programs. The goal of these services is to ensure that children with SED are able to live with their families and in their home community, whenever possible. The broad range of services that are provided through the children's SED program are as follows:

1) Individual Therapy
2) Family Education/Support/Therapy
3) Crisis Intervention
4) Collateral Contacts – treatment of an individual through necessary telephone or face-to-face contact with persons other than the identified child
5) Assessment and Evaluation
6) Psychological Evaluation
7) Group Therapy for Children with SED
8) Parent/Guardian Group Therapy
9) Intensive Family Services (IFS) – provided to families of youth under the jurisdiction of the Department of Corrections, which focus on resolving issues related to the child's successful return to the home
10) Liaison Services – consistent with treatment goals and intended to minimize the length of hospitalization

To be eligible for SED program services, the clinical record must contain documentation indicating that at least one child or adolescent in the family meets the criteria for being seriously emotionally disturbed. SED criteria are as follows:

1) The individual is under 18 years of age; or is 18 through 21 years of age and needs a continuation of services that were started before the age of 18 in order to realize specific service goals or during transition to adult services; and
2) The individual exhibits behavior resulting in functional impairment which substantially interferes with, or limits the individual's role or functioning in the community, school, family or peer group; and

3) The individual has a mental disorder diagnosed under DSM-IV-TR (V Codes not included); and
4) The individual demonstrates a need for one or more special care services, in addition to mental health services; and
5) The individual has problems with a demonstrated or expected longevity of at least one (1) year or has an impairment of short duration and high severity.

FY08 INTENDED USE PLAN

The South Dakota Division of Mental Health (DMH) received notification on April 1, 2008 from the Center for Mental Health Services that the approved FY08 budget included a decrease in mental health block grant funding totaling $30,308 for South Dakota. In response to this decrease, the Division of Mental Health modified the FY08 intended use plan to reflect the new funding level.

As stated in the FY08 State Plan, the Division of Mental Health allocates Block Grant funds towards services to adults with SPMI and children with SED. Section 1913 (a) of the PHS Act (42 USC 300x-3) requires that the State provide systems of integrated services for children with serious emotional disturbances (SED). Furthermore, the Block Grant states that each year, the State shall expend not less than the calculated amount for the Fiscal Year 1994. The FY08 intended use plan includes this level of funding for children's services. Therefore, the $689,452 allocated towards SED Children's Mental Health Services will remain at that level, and the decrease of $30,308 is addressed through administration and SPMI adult funding levels. Administration expenses were recalculated based on the new block grant funding level. All eleven community mental health centers receive Block Grant funds for services to children with SED.

The following is a list summarizing the activities that the FY08 CMHS Block Grant will fund:

Administration	$ 42,422
SPMI Adult Mental Health Services	$116,564
SED Children's Mental Health Services	$689,452
Total	$848,438

Block Grant Funding for each of the 11 community mental health centers will be as follows:

Community mental health center	Adult SPMI	Children's SED	TOTAL
Behavior Management Systems	23,610	186,152	209,762
Capital Area Counseling	0	41,367	41,367
Community Counseling Services	0	41,367	41,367
Dakota Counseling Institute	0	62,050	62,050

East Central Mental Health Center	0	6,895	6,895
Human Service Agency	43,800	55,156	98,956
Lewis & Clark Behavioral Health Services	49,154	103,418	152,572
Northeastern Mental Health Centers	0	68,945	68,945
Southeastern Behavioral HealthCare	0	75,840	75,840
Southern Plains Behavioral Health Services	0	27,578	27,578
Three Rivers Mental Health Center	0	20,684	20,684

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	28.60	30	32	33	34	35
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Ensure all children with SED and their families have access to appropriate mental health services across the state.

Target: Increase number of children with serious emotional disturbance served through the community mental health system.

Population: Children with serious emotional disturbance

Criterion: 2:Mental Health System Data Epidemiology
3:Children"s Services

Indicator: Number of children with SED served

Measure: Numerator: Numbers of children with SED served through state funding.
Denominator: Estimated number of children with SED.

Sources of Information: DMH information system, WICHE Estimation of MH Need, WICHE Mental Health Program http://psy.utmb.edu.

Special Issues: The FY08 target for the number of children with SED includes additional children who will be served through an expansion of funding received to alleviate waiting lists. The FY09 target includes the number of children estimated to be served through the FY09 budget request for expansion funds. Expansion amounts for FY10 are unavailable at this time. The Division will update this number in the implementation report due December 2008.

The DMH relies on a data collection system (STARS) to provide client information and process billing. State totals provide unduplicated counts of individuals served statewide. STARS is interfaced with the Department of Social Services' Medicaid Management Information System(MMIS) which has expansive capabilities specific to Medicaid eligible consumers. The DMH and the Department of Social Services work closely to ensure the two systems are compatible and HIPAA compliant.

Prevalence data from WICHE was used. The WICHE data was computed based on census information from 2000. This data assumes the growth in the number of children with SED is at the same rate as the total population.

Significance: Assuring access to mental health services for children with serious emotional disturbances is a priority of the Division of Mental Health and the mental health block grant legislation.

Action Plan: The Division of Mental Health will continue to explore opportunities for additional funding for services to children with serious emotional disturbance.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	1.05	3.99	3	3	3	3
Numerator	3	12	--	--	--	--
Denominator	285	301	--	--	--	--

Table Descriptors:

Goal: Provide a comprehensive, organized community-based system of mental health care for children with SED to include access to an array of appropriate services and resources.

Target: Maintain low 30 day inpatient readmission rate

Population: Children with serious emotional disturbance

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Rate of readmissions to State Psychiatric Hospitals within 30 days

Measure: Numerator: Number of persons, under age 18, who are readmitted to HSC within 30 days.
Denominator: Number of persons, under age 18, discharged from HSC during the past year.

Sources of Information: HSC information systems.

Special Issues: The number of re-admissions is comprised of a duplicate count (i.e., a child readmitted repeatedly would be counted at each readmission.)

Significance: Reducing the utilization of state psychiatric inpatient beds will be a reflection on implementation of Systems of Care within the community based mental health system.

Action Plan: The Division of Mental Health, the Human Services Center, and representatives from the Council of Mental Health Centers will continue to participate in a Discharge Planning workgroup to streamline discharge planning to ensure that all individuals, once discharged from the hospital, are aware of and have immediate access to mental health services in the community. Currently, this group is developing a standard process of information sharing between community mental health centers and the Human Services Center upon admission and discharge. In addition, a better process of assisting individuals with obtaining medications upon discharge has been implemented. As Systems of Care implementation continues, this workgroup will continue to explore opportunities to assist in reducing the utilization of state psychiatric inpatient beds.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	3.51	7.64	7	6	5	4
Numerator	10	23	--	--	--	--
Denominator	285	301	--	--	--	--

Table Descriptors:

Goal: Provide a comprehensive, organized community-based system of mental health care for children with SED to include access to an array of appropriate services and resources.

Target: Maintain low 180 day inpatient readmission rate

Population: Children with serious emotional disturbance

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Rate of readmissions to State Psychiatric Hospitals within 180 days

Measure: Numerator: Number of persons, under age 18, who are readmitted to HSC within 180 days.
Denominator: Number of persons, under age 18, discharged from HSC during the past year.

Sources of Information: HSC information systems

Special Issues: The number of re-admissions is comprised of a duplicate count (i.e., a child readmitted repeatedly would be counted at each readmission.)

Significance: Reducing the utilization of state psychiatric inpatient beds will be a reflection on implementation of Systems of Care within the community based mental health system.

Action Plan: The Division of Mental Health, the Human Services Center, and representatives from the Council of Mental Health Centers will continue to participate in a Discharge Planning workgroup to streamline discharge planning to ensure that all individuals, once discharged from the hospital, are aware of and have immediate access to mental health services in the community. Currently, this group is developing a standard process of information sharing between community mental health centers and the Human Services Center upon admission and discharge. In addition, a better process of assisting individuals with obtaining medications upon discharge has been implemented. As Systems of Care implementation continues, this workgroup will continue to explore opportunities to assist in reducing the utilization of state psychiatric inpatient beds.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Children with SED Receiving Therapeutic Foster Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Children with SED Receiving Multi-Systemic Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Children with SED Receiving Family Functional Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	64.32	65.19	67	70	72	74
Numerator	137	118	--	--	--	--
Denominator	213	181	--	--	--	--

Table Descriptors:

Goal: Provide a comprehensive, organized community-based system of mental health care for children with SED to include access to an array of appropriate services and resources.

Target: Increase in the number of youth reporting positively about outcomes by 2% each year.

Population: Children with serious emotional disturbance

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Number of youth reporting positively about outcomes

Measure: Numerator: Number of positive responses reported in the outcome domain on the youth consumer survey.
Denominator: Total responses reported in the outcome domain on the youth consumer survey.

Sources of Information: MHSIP YSS Survey

Special Issues: This indicator demonstrates positive responses on outcomes for individuals receiving services within the public mental health system. The survey tool used was the 28-item MHSIP Survey. The survey is completed on an annual basis with individuals receiving services from the eleven community mental health centers. 8 questions are analyzed in determining positive reporting of outcomes by consumers. Individuals filling out the survey must check “strongly agree” or “agree" to the following statements:
• I deal more effectively with daily problems
• I am better able to control my life
• I am better able to deal with crisis
• I am getting along better with my family
• I do better in social situations
• I do better in school and/or work
• My symptoms are not bothering me as much
• My housing situation has improved

Significance: Indication of positive outcomes play in important role in the development of systems of care and recovery oriented services.

Action Plan: The Division of Mental Health, community mental health centers, and the Advisory Council recognize the importance of culturally competent, child/family-driven, and strength-based mental health services with a systems of care approach. The Division of Mental Health will work closely with the Clinical Management Team and the Children's System of Care Steering Committee to further develop systems of care and include positive outcomes as criteria to determine the effectiveness of systems of care for children and families, which will be reflected in YSS MHSIP Survey responses.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Return to/Stay in School (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	14.75	23.33	25	27	29	31
Numerator	32	42	--	--	--	--
Denominator	217	180	--	--	--	--

Table Descriptors:

Goal: To increase the number of children with SED that report an increase in number of days in school as a result of receiving mental health services.

Target: Increase the number of children with SED reporting positively about school attendance by 2% each year.

Population: Children with serious emotional disturbance

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children''s Services

Indicator: Percentage of children and families who report an improvement in school attendance since beginning to receive mental health services.

Measure: Numerator
The number of children/families surveyed reporting improvement in school attendance/participation (both new and continuing clients)

Denominator
The total responses to school participation/attendance questions (both new and continuing clients)

Sources of Information: MHSIP YSS-F Survey

Special Issues: The YSS-F Surveys are conducted on an annual basis. A random sample of individuals that have received services during 3 months prior to dissemination of surveys are chosen. WICHE conducts the data analysis and completes the reports for the Division of Mental Health.

Significance: Increased school attendance is an important performance indicator in the development of systems of care for children with SED and their families.

Action Plan: The Division of Mental Health will work closely with the Clinical Management Team and the Children's System of Care Steering Committee to further develop systems of care and include increased school attendance as a criteria to determine the effectiveness of systems of care for children and families.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Child - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	8.33	42.86	35	30	25	20
Numerator	1	9	--	--	--	--
Denominator	12	21	--	--	--	--

Table Descriptors:

Goal: Provide a comprehensive, organized community-based system of mental health care for children with SED to include access to an array of appropriate services and resources.

Target: Decrease in the number of youth who report involvement with the juvenile justice system by 1% below current level.

Population: Children with serious emotional disturbance

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Percentage of youth arrested in year one who were re-arrested in yr 2.

Measure: Numerator: Number of youth reporting re-arrests in year two.
Denominator: Number of youth reporting arrests in year one.

Sources of Information: YSS MHSIP Survey

Special Issues: YSS Surveys are conducted on an annual basis. A random sample of youth(age 14-17)that have received services during 3 months prior to dissemination of surveys are chosen. WICHE conducts the data analysis and completes the reports for the Division of Mental Health. During FY07, the total number re-arrested during Year 2 jumped dramatically. The Division will be exploring reasons for this as we conduct further data analysis on survey results, and have pointed discussions with community mental health centers.

Significance: The Division of Mental Health recognizes that many children receiving community mental health services have been or are currently involved with the criminal justice system. It is a priority of the Division of Mental Health to decrease the contact with the criminal justice system that children/families receiving mental health services are experiencing.

Action Plan: The Division of Mental Health, the Advisory Council, and the community mental health centers are working together to develop performance indicators relative to criminal justice involvement. As system transformation to recovery oriented, individualized, strength based services occurs, we will work together to develop plans for decreasing of criminal justice involvement. Processes will include consumer/family involvement as much as possible, including involvement by the Children's System of Care Steering Committe

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	.02	.02	.02	.02	.02
Numerator	N/A	1	--	--	--	--
Denominator	N/A	4,735	--	--	--	--

Table Descriptors:

Goal: Provide a comprehensive, organized, community-based system of mental health care for children with SED and their families, to include access to an array of appropriate services and resources

Target: Decrease percentage of consumers reporting homelessness or living in a shelter.

Population: Children with SED receiving services in the community mental health system

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Percentage of children with SED that report homelessness or living in shelters

Measure: Numerator: Number of Children homeless (children under the age of 18)
Denominator: From URS Table, all persons with living situation, excluding persons with Living Situation Not Available (children under the age of 18)

Sources of Information: DMH information system

Special Issues: This performance indicator is only collected at admission and discharge. This performance indicator is a new performance indicator for the FY09-11 plan. This information was not collected prior to FY08.

Significance: Stability in housing is an important performance indicator assisting the Division of Metnal Health in the transformation of community mental health to a more recovyer-orented, child/family driven, integrated system of care.

Action Plan: Over the next three years, the Division of Mental Health and the community mental health providers, with assistance from the DIG grant, will be developing client level performance indicators around living arrangements and stability in housing. This client level data will be reported at various points in time during service delivery. Having this additional data will have a positive impact on policy planning and processes as the community system is transforming to a more recovery oriented system.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	87.08	83.52	85	87	89	91
Numerator	182	147	--	--	--	--
Denominator	209	176	--	--	--	--

Table Descriptors:

Goal: Provide a comprehensive, organized community-based system of mental health care for children with SED to include access to an array of appropriate services and resources.

Target: Increase the number of children/families reporting increase in social connectedness by 1% each year.

Population: Families of children with serious emotional disturbance

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Number of families of children with SED responding with increases in social connectedness

Measure: Numerator: Number of families of children with SED responding positively to questions related to social connectedness/social supports
Denominator: Total number of individuals responding to social connectedness/social support questions

Sources of Information: YSS-F Survey

Special Issues: This indicator demonstrates positive responses on outcomes for children and families receiving services within the public mental health system. The survey tool used was the 28-item YSS-F Survey. The survey is completed on an annual basis with individuals receiving services from the eleven community mental health centers. 4 questions are analyzed in determining positive reporting of social supports/social connectedness by consumers. Family members of children with SED filling out the survey must check “strongly agree” or “agree" to the following statements:
• I know people who will listen and understand me when I need to talk
• I have people that I am comfortable talking with about my child's problem
• In a crisis I would have the support I need from family or friends
• I have people with whom I can do enjoyable things.

Significance: The Division recognizes the importance of social supports/social connectedness for children and families receiving mental health services within the community mental health system. As the system transforms to a recovery oriented system, improved functioning is a very important indicator towards the quality of services.

Action Plan: The Division of Mental Health works closely with the Clinical Management Team and the Children's System of Care steering Committee to build a system that is responsive to child/family needs and wants, and allows the building of a natural support system and social connectedness for children and families. The Division will continue to measure social supports/social connectedness as one criteria for determining the effectiveness of system of care development.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	66.20	60.74	62	64	66	68
Numerator	141	164	--	--	--	--
Denominator	213	270	--	--	--	--

Table Descriptors:

Goal: Provide a comprehensive, organized community-based system of mental health care for children with SED to include access to an array of appropriate services and resources.

Target: Increase in the number of reporting increased levels of functioning by 2% each year.

Population: Families of children with serious emotional disturbance

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services
4:Targeted Services to Rural and Homeless Populations

Indicator: Percentage of families receiving CMHC services who report increased levels of functioning

Measure: Numerator: Number of families of children with SED surveyed who report increased levels of functioning
Denominator: Total number of responses reported on the statements above.

Sources of Information: YSS-F Survey

Special Issues: This indicator demonstrates positive responses on increased levels of functioning for children and families receiving services within the public mental health system. The survey tool used was the 28-item YSS-F Survey. The survey is completed on an annual basis with individuals receiving services from the eleven community mental health centers. Five questions are analyzed in determining positive reporting of social supports/social connectedness by consumers. Family members of children with SED filling out the survey must check “strongly agree” or “agree" to the following statements:
• My child is better able to do things he or she wants to do
• My child is better at handling daily life
• My child gets along better with family members
• My child gets along better with friends and other people
• My child is better able to compe when things go wrong

Significance: The Division of Mental Health does not have the numbers for FY05 actual, as this indicator was not measured at that time. The Division recognizes the importance of improved functioning for children and families receiving mental health services within the community mental health system. As the system transforms to a recovery oriented system of care, improved functioning is a very important indicator towards the quality of services.

Action Plan: The Division of Mental Health works closely with the Clinical Management Team and the Children's System of Care steering Committee to build a system that is responsive to child/family needs and wants, and allows the building of a natural support system and social connectedness for children and families. The Division will continue to measure social supports/social connectedness as one criteria for determining the effectiveness of system of care development.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Children receiving services in predominately frontier/rural areas

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	33	37	39	40	41	42
Numerator	257	289	--	--	--	--
Denominator	783	783	--	--	--	--

Table Descriptors:

Goal: Provide comprehensive mental health services to frontier/rural populations of children with SED and their families.

Target: Increase access to services in rural areas by 1% each year.

Population: Children with serious emotional disturbance and their families.

Criterion: 4:Targeted Services to Rural and Homeless Populations

Indicator: Number of children receiving services in catchment areas that are predominately frontier.

Measure: Numerator: Number of children with SED who receive services in the catchment areas of Three Rivers Mental Health Center and Southern Plains Behavioral Health Center.
Denominator: Estimated prevalence of children with SED in the catchment areas of Three Rivers Mental Health Center and Southern Plains Behavioral Health Services.

Sources of Information: DMH information system, Western State Resopurce Book: State Mental Health Authority Survey and Needs Assessment-WICHE Estimation Project (http://psy.utmb.edu/estimation/index_htm/South%20Dakota.htm)

Special Issues: Prevalence data estimates that the cathcment areas of Three Rivers Mental Health Center and Southern Plains Behavioral Health Services have lower rates of mental health services provided. When considering causal factors, the demographics of each county within these catchment areas provides insight into the combination of barriers to overcome. Consider (1) population per square mile, (2) percentage of Native Americans, and (3) percentage living under 100% of the federal poverty level.

TRMHC (1) (2) (3)
Corson 1.7 48.5% 42.5%
Dewey 2.4 66.6% 44.4%
Perkins 1.4 1.4% 15.2%
Ziebach 1.1 64.0% 51.1%

SPBHS (1) (2) (3)
Gregory 5.3 5.3% 21.6%
Mellette 1.6 46.7% 41.3%
Todd 6.0 82.4% 50.2%
Tripp 4.3 9.7% 20.6%

This data compares to Statewide averages of 9.2 persons per square mile, 8.3% Native American, and 15.9% under 100% of the federal poverty guidelines.

Shannon County also has a high concentration of Native Americans and a significant population living under 100% of the federal poverty level (respectively 94.7% and 63.1%). Shannon County falls into the Behavior Management Systems catchment area.

Significance: Behavior Management Systems, Three Rivers Mental Health Center and Southern Plains Behavioral Health Services provide services in the most rural areas of South Dakota. These agencies also serve three of four of the State's largest Indian Reservations. Assuring access to mental health services for children with SED and their families is a primary goal of the President's New Freedom Commission Report and for the Division of Mental Health.

Action Plan: The Division of Mental Health will continue to work with Behavior Management Systems, Southern Plains Behavioral Health and Three Rivers Mental Health Center in the provision of mental health services to individuals in their rural catchment areas. The Division will continue to allow both Southern Plains and Three Rivers to bill a rural SED rate that is 20% higher than the regular SED rate. In addition, the availability of telemedicine (which is reimburseable through Medicaid) has assisted both centers with the psychiatric shortage in those areas. The Division will continue to explore options for both Southern Plains and Three Rivers to continue to improve access for children and families in their catchment areas.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Individuals who are homeless, or at risk of homelessness, receiving PATH funds

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	23	18	20	20	20	20
Numerator	598	471	--	--	--	--
Denominator	2,603	2,603	--	--	--	--

Table Descriptors:

Goal: Provide comprehensive mental health services to homeless and rural populations of children with SED.

Target: Maintain the number of homeless individuals served through PATH.

Population: Adults with SPMI and children with SED and their families

Criterion: 4:Targeted Services to Rural and Homeless Populations

Indicator: Number of adults and children/families who are homeless, or at risk of homelessness, receiving PATH funds.

Measure: Numerator: Numbers of adults with SPMI and children with SED and their families who are homeless or at risk for homelessness, and who receive PATH housing funds.
Denominator: Estimated number of homeless individuals statewide

Sources of Information: PATH annual reports submitted by CMHCs and the 1999 Quantitative Assessment of Estimated Number of Homeless Adults, Children and Youth in South Dakota.

Special Issues: The number of homeless individuals served includes individuals that were provided outreach or contact, but not necessarily enrolled in PATH programs.

PATH final numbers are not due until December of each year. Therefore, FY07 and beyond are estimates based on final numbers served in FY06.

The Division of Mental Health does not foresee any additional funding through PATH. Therefore target percentages will remain the same through all three years of the grant.

Significance: Assuring PATH resources are being provided appropriately and according to the needs of individuals in the target population(s) is a primary goal of the mental health block grant law and a contingency of PATH funding.

Action Plan: The Division of Mental Health is working closely with PATH providers to ensure individuals are receiving services that are individualized, strength-based and provided with a recovery focus. The Division will also work with PATH providers to develop performance indicators and outcome mesures that will assist PATH programs in providing the highest quality of services possible to individuals that are homeless or at risk of homelessness.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑☐

Name of Performance Indicator: Participation in Treatment Planning

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	81	83	85	87	89	91
Numerator	173	145	--	--	--	--
Denominator	214	175	--	--	--	--

Table Descriptors:

Goal: Provide a comprehensive, organized community-based system of mental health care for children with SED to include access to an array of appropriate services and resources.

Target: Increase in the number of reporting positively about participation in treatment planning by 2% each year.

Population: Children with SED and families

Criterion: 3:Children"s Services

Indicator: Youth with SED reporting participation in treatment planning

Measure: Numerator: Number of youth with SED receiving CMHC services who report positively to participating in treatment planning
Denominator: Total number of youth responding to participation in treatment planning questions.

Sources of Information: MHSIP YSS Survey

Special Issues: This indicator demonstrates positive responses on outcomes related to participation in treatment planning for individuals receiving services within the public mental health system. The survey tool used was the 28-item MHSIP Survey. The survey is completed on an annual basis with individuals receiving services from the eleven community mental health centers. The youth must have positive responses— agree or strongly agree— to two of four survey statements “I helped to choose me services, I helped to choose my treatment plan goals, I was actively involved in my own treatment, and I, not staff, decided my treatment goals.”

Significance: Evidence of participation in treatment planning for youth receiving mental health services within the community mental health system is one of the highest priorities of the Division. As the system transforms to a recovery oriented system, consumer/family driven treatment is a very important indicator towards the quality of services.

Action Plan: The Division of Mental Health works closely with the Clinical Management Team and the Children's System of Care steering Committee to build a system that is responsive to child/family needs and wants-including ensuring full participation by the child/family in treatment planning. The Division will continue to measure participation in treatment planning as one criteria for determining the effectiveness of system of care development.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Public Funds expended on mental health services for children with SED

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	1,459	1,543	1,555	1,600	N/A	N/A
Numerator	6,444,522	7,163,242	--	--	--	--
Denominator	4,416	4,641	--	--	--	--

Table Descriptors:

Goal: Ensure resources for services to children with SED and their families are allocated based on consumer need.

Target: Increase the amount of public funds expended per child with SED in realtion to inflationary increases.

Population: Children with serious emotional disturbance

Criterion: 5:Management Systems

Indicator: Average amount of public funds expended on mental health services for children with serious emotional disturbance.

Measure: Numerator: Total amount of state funded direct service expenditures for children with SED in SFY.
Denominator: Total number of children with SED receiving services in SFY.

Sources of Information: DMH Information system

Special Issues: The Division of Mental Health cannot provide FY10 or FY11 budget information at this time. These budget requests have not gone through the necessary state channels to be finalized. As they are finalized, the Division of Mental Health will update to reflect changes.

Significance: Ensuring resources are allocated appropriately is a priority of the DMH.

Action Plan: The Division of Mental Health will continue to work with the Advisory Council and the community mental health centers to ensure public funds are continuing to be allocated according to consumer needs.

South Dakota

Planning Council Letter for the Plan

Upload Planning Council Letter for the Plan

South Dakota

Appendix A (Optional)

OPTIONAL- Applicants may use this page to attach any additional documentation they wish to support or clarify their application. If there are multiple files, you must Zip or otherwise merge them into one file.

Attachment 1

BYLAWS
MENTAL HEALTH PLANNING AND COORDINATION ADVISORY COUNCIL - SOUTH DAKOTA

(AS AMENDED AND APPROVED ON April 8, 2004)

ARTICLE I: NAME

The name of this organization shall be Mental Health Planning and Coordination Advisory Council, hereinafter also referred to as "Mental Health Advisory Council" (MHAC) and "Advisory Council" (AC).

ARTICLE II: AUTHORITY

The legal authority for the establishment and administration of the Mental Health Advisory Council rests in Section 1914 (c) of the Public Health Service Act (42 U.S.C. 30x-4). As Amended.

ARTICLE III: PURPOSE

Purpose of the Mental Health Advisory Council shall be to provide a leadership role in the development and implementation of the state comprehensive mental health services plan and to advocate that persons served by the mental health delivery system achieve their highest attainable degree of independence, productivity and integration into community life and receive quality health services.

ARTICLE IV: ACTIVITIES

The Mental Health Advisory Council shall meet at least quarterly unless otherwise determined by the council and its activities shall include, but not be limited to, the following:

Section 1. Advising. The Mental Health Advisory Council shall advise the Department of Human Services on all aspects of the development, implementation and modification of any necessary state or federal comprehensive mental health plans including funding, coordination of services, quality issues, policy related matters and matters relating to the Human Services Center and community mental health centers.

Section 2. Monitoring and Evaluating. The Mental Health Advisory Council shall, on a continuing basis review, monitor and evaluate the implementation of the state comprehensive mental health services plan and the mental health service system in South Dakota and provide for methods to evaluate the quality of that service network.

Section 3. Reporting. The Mental Health Advisory Council shall transmit its comments and reports to the Governor of South Dakota and the Secretary of the US Department of Health and Human Services as required by the state and federal statutes governing its activities.

Section 4. Coordinating. The Mental Health Advisory Council shall advise the Department of Human Services to achieve greater coordination of planning and service delivery efforts among the various agencies involved in the mental health service delivery network and shall continually work for needed system expansion and highest quality service.

Section 5. Advocacy. The Mental Health Advisory Council shall serve as an advocate to all individuals needing mental health services within the state.

ARTICLE V: MEMBERSHIP

Section 1. Appointment. Members of the Mental Health Advisory Council shall be appointed by the Governor from among the residents of the state with consideration for reasonable geographic representation from the entire state.

Section 2. Composition and terms. The Mental Health Advisory Council membership and terms of membership shall be in accordance with requirements set out in Section 1914 (c) of the Public Health Service Act (42 U.S.C. 30x-4).

The council shall consist of the following who shall be appointed by and serve at the pleasure of the Governor:

1. The director of Division of Mental Health, or designee;
2. The director of the Office of Education Services & Supports or designee;
3. The director of the Division of Rehabilitation Services, or designee;
4. The State Court Administrator, or designee;
5. The executive director of the S.D. Housing Development Authority, or designee;
6. The secretary of the Department of Social Services, or designee;
7. A representative of Indian Health Services, whose initial term shall expire June 30, 2003; future terms shall be 3 years;
8. A qualified mental health professional who provides direct services to adults with severe and persistent mental illness in an approved community mental health center (not a center director), or the Human Services Center, whose initial term shall expire June 30, 2004; future terms shall be 3 years;
9. The administrator of the South Dakota Human Services Center, or designee;

10. A representative of the South Dakota Council of Mental Health Centers, whose initial term shall expire June 30, 2005; future terms shall be 3 years;
11. The secretary of the Department of Corrections, or designee;
12. A qualified mental health professional who provides direct services to children with serious emotional disturbances in an approved community mental health center (not a center director), or the Human Services Center, whose initial term shall expire June 30, 2003; future terms shall be 3 years;
13. A family representative of a child (under eighteen years) with a serious emotional disturbance, whose initial term shall expire June 30, 2003; future terms shall be 3 years;
14. A family representative of a child (under eighteen years) with a serious emotional disturbance, whose initial term shall expire June 30, 2004; future terms shall be 3 years;
15. A family representative of a child (under eighteen years) with a serious emotional disturbance, whose initial term shall expire June 30, 2005; future terms shall be 3 years;
16. A family representative of an adult (eighteen years or over) severely mentally ill individual, whose initial term shall expire June 30, 2004; future terms shall be 3 years;
17. A representative of a statewide family support and advocacy group, whose initial term shall expire June 30, 2005; future terms shall be 3 years;
18. A primary consumer of mental health services with preference for an adolescent that is at least 15 years of age and under 22 years of age at the time of appointment, whose initial term shall expire June 30, 2003; future terms shall be 3 years;
19. A primary consumer of mental health services, whose initial term shall expire June 30, 2003; future terms shall be 3 years;
20. A primary consumer of mental health services, whose initial term shall expire June 30, 2004; future terms shall be 3 years;
21. A primary consumer of mental health services, whose initial term shall expire June 30, 2005; future terms shall be 3 years;
22. A representative of a statewide mental health consumer organization, whose initial term shall expire June 30, 2004; future terms shall be 3 years;
23. The executive director of the South Dakota Advocacy Services, or designee;
24. A public educator or administrator, whose initial term shall expire June 30, 2005; future terms shall be 3 years; and
25. A family representative of an adult (preference for but not limited to a person sixty-two years of age or over) severely mentally ill individual, whose initial term shall expire June 30, 2003; future terms shall be 3 years;

26. A family representative of an adult (eighteen years or over) severely mentally ill individual, whose initial term shall expire June 30, 2005; future terms shall be 3 years.

Primary consumers and family representatives must be or represent current or prior recipients of public mental health services. For the three positions for a family representative of a child (under eighteen years) with a serious emotional disturbance, the preference is to have representation, at the time of appointment, of children in early childhood (under 6 years of age), elementary (ages 6-12 years of age), and high school (ages 13 to 17 years of age). Future terms of those members with established terms shall be three years. Members may not be appointed for more than two, consecutive three year terms.

Section 3. Attendance. Council members, with the exception of those specifically mentioned in the Bylaws, may not designate persons to attend meetings or vote on their behalf.

Those members allowed to designate and who choose to do so shall designate in writing a representative who will attend in the appointed member's absence and shall convey the name of the designee to the Department of Human Services. A designee shall be considered a council member in all respects until a change in status is conveyed to the Department of Human Services in writing by the person who designated or his successor.

Council members and designees shall notify the Council staff when they are unable to attend a meeting. If a Council member has more than two absences per Council year, the Governor's Office shall be notified and asked to contact the appointee concerning that appointee's willingness to continue to serve on the Advisory Council. If a designee has more than two consecutive absences the person who appointed the designee shall be notified. The Council Year shall be from July 1 to June 30 of the following year.

Section 4. Resignation. Any member desiring to resign from the Council shall submit his resignation to the Governor's Office and send a copy of the letter to the Department of
Human Services and the Council Chairperson. This individual will remain a member of the Council until such time as the Governor's Office is able to fill the vacancy.

Section 5. Financial Compensation. Members shall serve on the Council without compensation, except that members and designees shall be reimbursed for travel expenses as set forth in Title 5 of the Administrative Rules of South Dakota. Reimbursement for travel expenses shall be provided for a person attending with council members who require such assistance to participate. Reimbursement for other expenses, e.g., attendant care services, interpretive services, telephone, postage, etc., necessary to allow for participation and fulfillment of council responsibilities by council members shall be coordinated with and approved by the Department of Human Services.

ARTICLE VI: OFFICERS

Section 1. Positions. The officers of the Council shall include a Chairperson and Vice-Chairperson. At no time may the positions of Chairperson and Vice-Chairperson be simultaneously held by persons who provide mental health services, or represent an organization that provides mental health services or represent an organization whose members provide mental health services.

Section 2. Duties.

(a) Chairperson. The Chairperson shall preside at all meetings of the Council. The Chairperson, in cooperation with the Council, Council staff and the Department of Human Services shall schedule all meetings of the Council and perform all such duties relative to the office. The Chairperson in furthering the purpose and activities of the Council may represent the Council in dealings with other organizations and at public meetings and conferences, or may designate a council member as the Chairperson's representative.

(b) Vice-Chairperson. The Vice-Chairperson shall act as Chairperson in the absence of the Chairperson. In the event of the resignation, incapacity, or death of the chairperson, the Vice-Chairperson shall serve as Chairperson until the council elects a new Chairperson. The Vice-chairperson shall perform other duties as may be assigned by the Chairperson.

Section 3. Nominations. Nominations for Council officers shall be made from the floor.

Section 4. Elections. The Council officers shall be elected by Advisory Council membership. Elections shall be held during the last quarter of the council year. Election to office shall be by a majority of members attending and voting.

Section 5. Eligibility to Hold Offices. Officers shall be selected from those members who are not subject to the absence notification provision of Article V, Section 3.

Section 6. Terms. The term of office for the Chairperson and the Vice Chairperson shall be two years. Members may hold the same office for more than one term provided there is an interval of two years between terms.

Section 7. Vacancies. Vacancies in elected offices shall be filled by a majority vote of the members in attendance at the next Council meeting after the vacancy occurs. Officers so elected shall serve for the remainder of the vacated term and shall be eligible for election to that office for the next full term.

ARTICLE VII: MEETINGS

Section 1. Schedule.

(a) Regular. The Council shall meet at least quarterly.

(b) Special. Special meetings of the Council may be called by the Chairperson or by the Chairperson at the request of 10 council members.

Notice of special meetings shall be made to all Council members not less than 10 days prior to the meeting stating the time, date, location and purpose of the meeting. No other business shall be transacted at a special meeting.

Section 2. Quorum. A quorum for an Advisory Council meeting shall be fifty percent (50%) of the appointed membership.

Section 3. Agenda and Supporting Materials. An agenda and supporting materials for a regularly-scheduled meeting shall be distributed 10 days in advance of the meeting. Requests for items to be included on the agenda shall be submitted to the Chairperson at least fifteen (15) days prior to the meeting. The Chairperson shall coordinate agenda development and distribution with Council staff. Agenda items may be added at any meeting with the approval of a majority of the members attending.

Section 4. Open Meetings Law. All meetings shall be open to the public in accordance with the state open meetings law, set out at South Dakota Codified Laws 1-25-1.

Section 5. Voting. Voting shall be by advisory council members present. Voting by proxy shall not be permitted. A person designated as provided for in Article V is not a proxy.

Section 6. Public Notice. Public notice of all meetings shall be given by posting the agenda at the Division of Mental Health at least 24 hours prior to any meeting as set forth in SDCL 1-25-1.1.

ARTICLE VIII: COMMITTEES

The Council shall have necessary standing committees to adequately conduct the affairs of the Council. These standing committees shall include a children's services sub-committee, an adult services sub-committee, and a Mickelson Center sub-committee. The standing committees may include members that are not members of the Mental Health Planning and Coordination Advisory Council.

Committees to be created under this Article shall be approved by a majority of the Council membership at any regular or special meeting.

Committees shall represent the Council when authorized to do so by the Council or Chairperson. Committee members shall be appointed from the Council membership by the Chairperson taking into consideration requests by the Council membership to participate in specific committees.

The Chairperson may appoint ad hoc committee members who are not council members provided however that non council members shall not participate in council voting.

ARTICLE IX: PARLIAMENTARY AUTHORITY

Council meetings shall be conducted in accordance with the rules contained in the current edition of *Roberts Rules of Order Newly Revised* in all cases in which they are applicable and in which they are not inconsistent with these bylaws and any special rules the Council may adopt.

ARTICLE X: AMENDMENT OF BYLAWS

These Council bylaws may be amended at any meeting of the Council by a majority vote of the appointed Council membership in attendance provided the amendment has been distributed to all Council members at least 10 days prior to the date of the meeting.

ARTICLE XI: CONFLICT OF INTEREST

It shall not be considered a conflict of interest for any individual or an employee, officer, or director of any firm, corporation, department, facility or agency to serve as a member of the Council provided such member shall abstain from action and voting by the Council in matters where the member may receive a direct personal financial benefit from a contract or grant awarded by the Council.

ARTICLE XII: DESIGNATED STATE AGENCY

The Advisory Council shall be assigned to the Department of Human Services.

ARTICLE XIII: COUNCIL STAFF

Technical assistance and staff support shall be provided to the Mental Health Advisory Council by the Department of Human Services.

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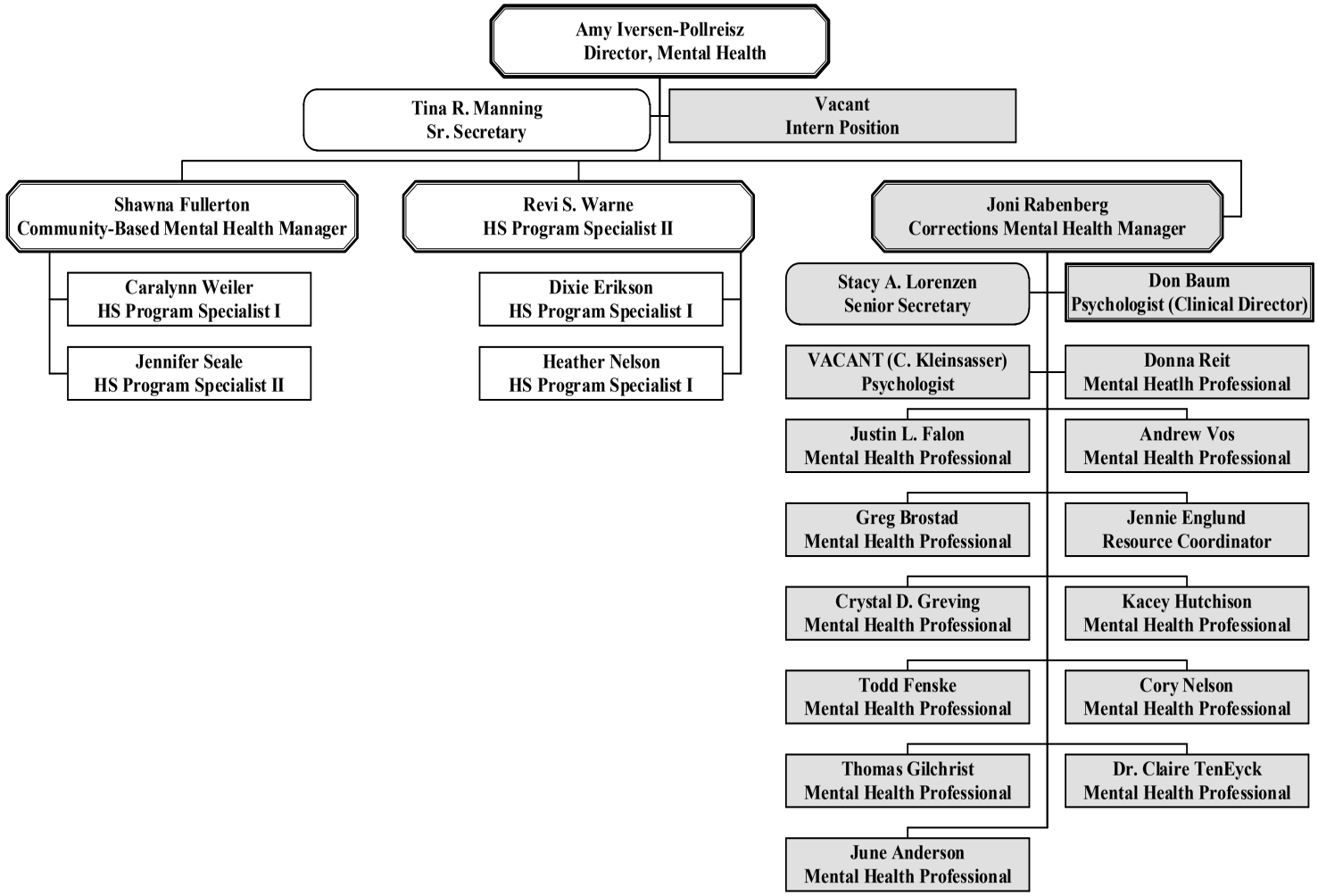
Division of Mental Health (1981)

08/20/07



South Dakota Mental Health Center Service Areas Attachment 4